THE OBSTETRIC GAZETTE.

Vol. VII. — FEBRUARY, 1884. — No. 2.

Original Articles.

POSTERIOR SECTION OF THE UTERINE CERVIX IN A VIRGIN FOR DYSMENORRHEA.—FOLLOWED BY SERIOUS NERVOUS SYMPTOMS.—RELIEVED BY TRACHELORRHAPHY.

Reported to the Cincinnati Obstetrical Society, November 8th, 1883,
By THAD. A. REAMY, M.D.

March 28, 1882, I was consulted by Mrs. T., a widow, with reference to the health of her daughter, who accompanied the mother to my office. The patient was a blonde, twenty-three years of age, of medium height, well proportioned, except that she was now somewhat emaciated. She was pale, anæmic, nervous. The following history was obtained: She menstruated at 15; she was now in school; being very bright, was at the head of her classes, very ambitious. Two years later, at the age of 17 years, still attending school, menstruation became irregular and painful. The inter-menstrual period sometimes prolonged to eight weeks, at others but two or three weeks intervening. The patient became anæmic, slept badly, complained of pain in the hips, groins and legs. After several months of suffering, still trying to maintain her place in school, she was placed under charge of a gentleman having some reputation as a gynecologist. He recognized, as he stated to the family, the necessity for a digital examination per vaginam. This was at first refused but as the family had unbounded confidence, the examination was finally permitted. The diagnosis announced was slight prolapsus of the uterus with retroflexion, associated with ulceration of the os. The patient was at once ordered to abandon school and within a few weeks was forbidden to leave her bed. For one year she was subjected on an average of three times per week to the introduction of a speculum and the application of various medicaments to the ulcerated (?) os. The vagina, meantime, being packed with wads of cotton alternating with hot water irrigation. Sponge tents were from time to time introduced into the cervix in order to secure such dilatation as would admit of free menstrual flow and thus relieve the unbearable dysmenorrhea. All this, notwithstanding the youth and temperament, the anæmia, nervous excitability of the victim. Subsequently, medicines were introduced into the uterine cavity, or attempted to be so introduced, for the cure of supposed

endometritis, which was now added to the long list of serious maladies which, in the opinion of her medical adviser, were present.

As the patient grew no better, but worse, posterior division of the uterine cervix was boldly performed with the scissors, the incision extending nearly to the posterior cervico-vaginal junction. This was stated to be necessary in order to straighten (?) the cervical canal, and widen it.

Strange to say, this afflicted person survived, and escaping from the skill of her surgically inclined friend, ran the gauntlet of patent nostrums, health resorts and doctors; the latter she tried in different States, consulting one or two men of eminence.

At the time of my examination she was a picture of mental and physical suffering. Such had become her nervous irritability that she could scarcely sit quietly in the chair for five minutes at a time. She presented symptoms bordering strongly upon chorea. There was no pulmonary or cardiac disease, though the heart's action was irritable and a slight anæmic bruit could be detected over the base. Marked fatigue was reported upon the slightest physical or mental exercise. Menstruation was now regular as to time; quantity scanty, painful. Neuralgic pains of the most violent character were complained of, reflecting from the lower pelvic region down the thighs and upward to the lumbar region. Appetite poor, patient frequently suffering from nausea, especially in the morning hours.

A digital examination per vaginam, which I felt myself justified in making after obtaining her *medical* and *surgical* history, revealed the cervical section above referred to with the divided edges widely separated, sufficiently so, at the os, to indicate that probably a wedge-shaped piece of tissue had been removed at the time of section. So widely were the edges separated, so thoroughly were they indurated and thickened, that the deformity was striking. An extensive cicatricial deposit could easily be detected in the apex of the original wound.

An examination by the speculum (Sims') verified and even exaggerated the above description. The uterine probe was carried into the cavity. Some difficulty was encountered in passing the point of cicatricial deposit, otherwise it entered freely. Measurement from os externum to fundus three inches; carrying the sound back into the slit, of course, measurement was much less.

April 25th, not quite one month subsequent to this examination, assisted by Drs. E. W. and G. S. Mitchell, the patient being etherized, I made trachelorrhaphy, removing all ciatricial deposit and closing the wound with six silver sutures. The sutures were removed on the fifteenth day. The result was perfect. Four months subsequently the patient had gained fifteen pounds in weight and was free from pain. Six months subsequently her health was perfect. She is now married and living in a

distant State. I am unable to say at present whether she will be fruitful or not.

Of course it is useless for me to add that this was an humiliating illustration of the perversion of judgment which fastens upon some men in our profession should they fall into special lines of professional work. This order of specialism is a curse to our art, a curse to its victims. It brings blight instead of blessing. No man can be a safe specialist who is not an educated and practically safe general practitioner, though he may do but little general practice; he must have had practical and experimental training in this way.

If the attendant upon this poor girl had recognized in her dysmenorrhœa simply the fruits of an over-taxed brain, anæmia, and nervous exhaustion, and had enjoined absence from school and study, nutritious diet, cold sponge baths, iron and bitter tonics, free exercise in the open air (including, probably, change to country for a season), a few months would have been ample for her complete restoration to health. But, unfortunately, being a monomaniac upon the subject of local disease, and knowing no locality but the sexual system, he was unable to recognize the difference between local organic disease and mal-nutrition. If he had lost the capacity himself to exercise any functions but those of a specialist, he should have turned this case over to some intelligent general practitioner.

I wish to embrace the present opportunity of entering my protest against the growing practice of subjecting young misses to digital and speculum examinations upon the most trivial complaint, under the ignorant impression that every ache in the lumbar or pelvic region means ovarian or uterine disease, or both, almost always signifying ulceration with displacement(?). Such conclusions are too absurd to command any candid answer. Such conditions in such subjects are extremely rare, and generally due, when found in such subjects, to special and extraordinary causes, constituting a special group of cases which have nothing, in common, with the above diseases.

I must be pardoned for insisting that it is not a trifling matter to subject a young girl to even a digital vaginal examination. It is a shock to her nervous system which nothing but the strongest evidence of disease demanding it can justify. The mortification and demoralizing influence of such treatment upon the subjects here spoken of should challenge every conscientious and true physician to save these young persons from such an evil. I am aware that in certain quarters I shall be charged with here giving expression to a sentiment rather than to science.

No matter. Being now almost exclusively engaged in gynecological practice, I have opportunity to know the extent to which the evil referred to is growing. I should forfeit my own self-respect, and refuse to obey

the order of a sacred duty, were I to remain silent. Moreover, outside of the social and moral aspects of the case as presented, such practice leads to disease, not to health. On this ground, therefore, it should be condemned.

CHRONIC NASAL CATARRH IN CHILDREN.

A Paper read before the College of Physicians of Philadelphia, January 12, 1884, by

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Professor of Physiology in the University of Pennsylvania.

In many instances the clinical history of a case of chronic nasal catarrh in the adult embraces groups of symptoms which belong to the period of childhood. Comparisons of numbers of such histories force the observer to the conclusion that the juvenile phase of the disease includes various conditions of the nasal chambers, and of the pharynx. A lady, aged thirty, reporting for the treatment of a catarrh which had persisted from the seventh year, recalled the distress at the time experienced from the frequent passage of mucus from the naso-pharynx to the oro-pharynx. A young man, aged twenty, who suffered from obstruction of the nasal chambers, and whose tonsils were normal at the time of examination, remembered the fact that these bodies were of large size when he was quite young. A third patient, aged thirty-five, suffering from copious muco-purulent discharge from the nose, complicated with pharyngitis, was confident that the habit of hacking had annoyed him as early as his ninth year to as great a degree as at the date of reporting for relief. While it must be conceded that the recording the clinical history of an adult, allowance must be made for lapses of memory and for the probable coexistence of exanthematous and of diphtheritic sore throats, it is certain that some of the little patients who come under our care exhibit symptoms which are apt to persist in some modified form in adult life.

In the light of such evidence it becomes a matter of interest to ascertain what peculiarities, if any, are to be found which charactize chronic nasal catarrh in children.

Accepting as an axiom that this disease cannot be appropriately studied without a correct understanding of the structures of the nasal chambers, it must follow that the differences between the adult and other juvenile phases of the disease may be expressed in some degree by the differences between the peculiarities of the chambers themselves at the two periods.

In the child the vestibule is small, the floor is raised, the inferior meatus is shallow, the mucous membrane is of a delicate red color, and the eminences corresponding to the anterior ends of the inferior turbinated bones are rounded, and relatively of greater length than in the adult.

In part owing to the difficulties, and in part to inherent distinctions the juvenile aspect of the disease is marked by a number negative features.

Thus, the membranes are never infiltrated with the products of inflamation, or corrugated, or ulcerated. The septum is never, or almost never, deflected, unless a history of injury explains such deflection. Disease is never located above the respiratory tract. Atrophic catarrh is unknown.

Symptomatology and Diagnosis. — Congestion and acute inflammation of the nasal mucous membrane is common in childhood. The discharge in the begining of the attack is almost always mucoid. The serous stage so commonly present after profound impression in adults, is not recognizable, and the transition is usually abrupt between a discharge of mucus to one of muco-pus. If air passes freely through the chambers the discharge is apt to dry and to form "crusts" or "scabs". These collect for the most part in the vestibule, though they may form at any portion of the respiratory tract. The discharge will often remain muco-purulent throughout the entire treatment, so that instead of expecting a return of the mucoid stage the practitioner should look forward to a gradual cessation of the amount of the discharge. The muco-pus in favorable cases becomes thicker as the case improves, and toward the close is often of the consistence of curd.

The child either "sniffles" in order to draw into the nose the discharge which, from the shallowness of the vestibule, inclines to flow outward from the nostrils, or it exhales or "hawks" if it inclines to fall into the pharynx. By careful observation of these acts it can be ascertained that the place to which the discharge is most annoying (all things remaining the same), is also the place at which the greatest amount of obstruction exists.

Should the tonsils be very large and establish mouth breathing, care should taken not to confound the tumid state of membranes of the nasal chamber with the evidences of local disease. Although the two conditions of nasal catarrh and enlargements of the tonsils often exist together, they need not.

When tumid tonsils are present the probabilities are in favor of the adenoid growths at the roof of the pharynx being in the same condition. The naso-pharynx in such patients is occupied with tenacious mucoid discharges. The nasal chambers and the naso-pharynx considered as parts of a single chamber are shut off from communication with the oro-pharynx and the normal downward flow of mucus prevented. The mucus can be at times brought away through the nose by a handkerchief, and the impression may be erroneously received that the discharge, instead of being pharyngeal and mechanically retained, is catarrhal, and that it originates in the nose.

It need be scarcely necessary to say that the presence of mucus in a naso pharynx which is thus narrowed, the danger to aural complication is decided, and, while the condition is not one admitting of classification

with cases of true nasal catarrh, the disease of the nose and ear are inextricably associated.

The general health is rarely good, and symptoms which relate to malnutrition are so pronounced that they have received careful attention at the hands of the writers on diseases of children.

Etiolgy.—Chronic catarrhal states in childhood are invariably associated with other effects of malnutrition. While this is not a novel statement, it is at least one which has been imperfectly formulated. Such effects should not be dismissed as being simply those of scrofula and of rickets, but should be exactly referred, as far as it is possible so to do, to the laws of development. Many conditions are present in patients who suffer from catarrh, which may be called errors in development. It is true, these errors are not of the kind denominated "variation" or "anomaly" but are pathological, and may be regarded as the results of precocity or retardation occurring in rapidly growing tissues. They are conspicuous in bone tissue, tooth tissues, skin tissues, lymphatic tissue, and in nerve tissue.

From the earliest period in development to its completion at the twenty-first year, disease will modify structural processes much more readily and profoundly than at any subsequent period. The tissues may be said to be more plastic during the formative period and to retain the impress of morbid action a longer time than in the adult, and to carry into the future the results of this impress in altered relation or proportion of the formed elements. It is not intended in this place to show that chronic nasal catarrh is in any respect peculiar in this regard, but to invite attention to the operation of such forces which appear to have escaped detection.

The period of childhood is marked by changes as great in the proportions of the parts of the head and face as in any other of the body. The growth of the brain and the development of the permanent teeth are among the more striking of these. Clinical writers lay great stress upon the influence exerted upon the economy, by the errors of cerebral and dental growths. Are the influences they exert in the etiology or in the maintenance of nasal catarrh to be ignored?

The condition of the development of the brain in connection with those of the nasal chambers while one of great interest presents difficulties for the investigator since the examination of large numbers of examples would be required before conclusions worthy of credence could be reached. Ophthalmologists have indeed, noted that the accelerated rates of development of the brain exist with a disposition to myopia. If such be the case, it is rational to conclude that the shapes of the nasal chambers will be in correlation with the states of the olfactory nerves, and thus the influence which exists between the brain and the eye will be found also to exist between the brain and the nose. The extent to

which chronic nasal catarrh may be found among myopes cannot be formulated.

There is no doubt that the patients are as a rule in an unnatural mental condition. The mind is either precocious or dull; the temper is irritable and the disposition intractable; digestion is delicate, and reflex disturbances arising therefrom are of frequent occurrence. The patients belong to the class of subjects that develop morbid appetites, and, in girls, yield to the predisposing causes which create so much disturbance at the approach of puberty. Chorea is occasionally noticed as a complication. In one example, a child of precocious intelligence, of delicate constitution, and who had nearly perished during an attack of acute pleurisy, the habit of exhaling air from the nostril was acquired after all symptoms of catarrh had ceased.

The fact that with chronic nasal catarrh, errors of development of the teeth and rates of growth and nutrition of the nails are often associated, it is convenient to examine the relations between the nails, teeth, and other structures. By way of introduction to this topic, it can be said that in pathology the connection between the hair, the nails, and the teeth are numerous. (1)

Abnormal development of the teeth occurs in congenital hypertrichosis. Hair and teeth are commonly found in dermoid cysts. In man, and in ruminants, hairy warts are found upon the cornea. In congenital syphilis, the cornea, the teeth, and the nails are all liable to peculiar inflammatory invasions. Is it not more than a surmise that since all these structures—the hair, the nails, enamel-organs—and cornea, arise from the *epiblast*, and are strictly tegumental in nature, that they may be found effected together? Be this as it may, the nails and the teeth are certainly to be considered together in studying chronic nasal catarrh in children, the nails at all times, and the teeth during the formative period of the enamel-organs. (2)

Through the courtesy of Dr. J. Wilks O'Neill, the attending physician to the Southern Home for Destitute Children, I have recently examined ninety-six children, with the object in view of determining to what de-

1 From the fact that the writer's biological and clinical studies have been pursued conjointly, he trusts that it may be thought admissible to introduce at this place some reflections concerning the nails and the teeth. These structures are of co-relative value in mammals generally. Blunt, flat teeth are always associated with hoofed digits, and sharp, conical teeth with clawed digits. Adopting the methods of the evolutionists, it may be assumed that the same forces which have operated in changing the forms of teeth are also operative in changing the forms of the hoofs and claws. This co-relation is not found in the earliest of the mammalia. In the process of evolution the quadrupeds, as they exist about us, from the few generalized types known to have flourshed in the past, it can be inferred that the impress upon the nutritive processes which would effect the forms of the teeth, would also impress the entire tegumental series of the organism, not only the teeth and the nails would be in common affected by common causes, but the hair as well. Confining these remarks however, to the nails and the teeth, it is probable that the changes of food-supply necessitating corresponding changes in habit would most probably effect the claws and hoofs sooner than the teeth, since the latter are more resisting, and, at least, in many genera are completely formed while the claws and the hoofs are of continuous growth, and would be more readily influenced by changes in the surroundings.

2 Among the applications of the rate of the growth of nails in connection with diseased states, reference may be made to papers by Dr. S. Weir Mitchell on paralysis, Dr. J. M. DaCosta on typhoid fever, C. E. Hasse on cyanosis, and Poland and Langenbeck on aneurism.

gree a connection could be traced between the teeth and the nails in individuals, many of whom, if not all, were known to have been subjected to neglect and to the various inherited effects which could reasonably be accepted as tending to retard development.

Of the entire ninety-six, fifteen children had white spots on the finger nails in abundance; five of these had decided defective dental development—that is to say, excessively chalky enamel—distorted and disfigured crowns, etc. Three had moderately chalky crowns, but no distortion. Seven had no appreciable defect.

No defective teeth were found in the remaining eighty-one children, so that the existence of dental defect exactly correlated with the spotted finger nails. Of the fifteen children thus selected, a little less than half the entire number had spotted nails but no dental defect. No attempt was made to ascertain any defect of rate of eruption for the data obtained from the inmates of an asylum for destitute children would be unreliable. It would be increased rather than diminished by more careful examinations made by dentists or other persons accustomed to detect minute abnormalities. Concerning the defective teeth and nails, it is conceded that they have arisen from acute illness, as in the exanthemata, or from gingival inflammation, as in congenital syphilis. The "measles-tooth" was found but in a single individual, whose case was not enumerated. For the rest, it is quite possible some of the appearances may have been due to syphilis, though the pegged tooth was found in a single instance only. No account was taken of the occurrence of catarrh in the inmates, for, although it is probable the condition existed, it was not reported as present by the attendants. The disease is rarely recognized among the children of the poor, where the symptoms are not likely to receive attention.

From a careful study of nine patients, from the writer's practice, it was found that five exhibited white spots on the nails of the hand, and defects in the form and irregularity of rates of erruption of the teeth. In a young lady, aged fifteen, who came under care for this phase of catarrh, the superior lateral incisors had never been erupted, while the left deciduous superior canine tooth had remained in the arch. In a second case of a girl, fifteen years of age, who had been much neglected, the depression remaining upon the vortex (answering to the anterior fontanella,) was conspicuous, the teeth were irregular, the vault of the hard palate high and narrow, the disposition shrinking and irritable, and the mental faculties dull. In such patients the epiphyses of the bones will be seen to be too large for the shafts, particularly in the case of the radius as it enters into the composition of the wrist-joint. At the same time, the finger-nails are often marked by white spots, and the teeth, with milky opacities of the enamel.

The bones being slow in growth, the function of manufacture of blood-

corpuscles is largely withheld from the medulla and retained for a longer period than is natural in the blood-vessel-glands, notably the thyroid body, the tonsils, and the lymphatic glands. Hence a disposition exists for these structures to undergo hypertrophy. If this method of reasoning be accepted it is evident that the presence of enlarged tonsils need not be regarded as a primary cause of the condition above outlined, though doubtless they may aid in a secondary manner in obtaining morbid determination of blood about the head, and if they are sufficiently bulky, to cause obstruction in respiration while the mouth is closed, will in themselves create a class of disturbances peculiarly their own. All that is to be emphasized in this connection is the fact that the causes of tonsil-enlargement are due to nutritive conditions which are part of the history of the lime-selecting and the blood-making tissues everywhere in the body.

Frequency and Diagnosis.—From a somewhat extended experience in the treatment of these and allied disorders, the writer has concluded that chronic nasal catarrh in the child is a rare disease, and must be separated from the catarrhs which are so common with the children in this community. A child otherwise healthy, who contracts a severe cold may have a duration of the nasal discharge for a time, which excites the apprehension of the parents, and the advice of the physician is asked. If no other sign exists but the discharge, that is to say, if the characters already enumerated are absent, the case can be diagnosticated, *subacute nasal catarrh.* If, however, in connection with the discharge, distinct evidences of malnutrition exist—as instanced in the skeleton—in the tonsils, nails, and teeth, the diagnosis of *chronic nasal catarrh* can be made.

Congenital Malformation.—While causes operating upon the fœtus may be said to create the conditions which have just been recognized, it is also true that an entirely distinct class of pre-natal influences is effective in creating nasal catarrh. In a case of absolute atresia of both nasal chambers—with which condition was associated defective speech—the effect to the ear of the listener was almost identical with that produced in cases of cleft palate, notwithstanding the fact that the palatal and the pharyngeal mechanism were normal. In another case, that of a child three years of age, it was noticed that after an attack of scarlet fever the child could no longer breathe through the nose. The parents were inclined to attribute this condition to changes brought on in the nose by the attack of illness. Inasmuch, however, as the left side was absolutely occluded and the right side merely permitted a cotton-tipped probe to pass through into the pharynx; and in addition, the fact that the hard palate was narrowed and very high arched, while lachrymal obstruction and fistules existed on both sides being more on the left, the conclusion was drawn that the condition was congenital, and was due to errors in the formation

of the bones in the face. In this case the angles of the mouth were excoriated, the cervical lymphatic glands were enlarged, and the existence of congenital syphilis, although the teeth were not pegged nor the cornea hazy.

Effects of Local Injury.—The extent to which local injury influences the shape of the nasal chamber has a special bearing upon the subject of nasal catarrh in children. As a result of the frequent falls upon the face, it has been assumed that the deflection of the nasal septum which is so common in the adult, may arise from this cause. While it is conceded that blows on the nose may deflect the septum and thus induce obstruction and nasal distress, it is in the experience of the writer a rare occurrence. He has met with four cases only of such a condition, and in one of these a marked hereditary condition existed in other members of the family to nasal catarrh.

Prognosis.—The prognosis of simple cases of acute, and of subacute nasal catarrh is always favorable. The prognosis of the chronic cases should be guarded. Success depends to such an extent upon the recuperative power of the constitution of the patient, and to the character of the surroundings, that it is difficult to fix upon any one issue to all cases. It has already been seen that if neglected, the disease may be as noticeable in adult life as in childhood. Assuming the premises as to the nature of chronic nasal catarrh to be correct, it is evident that a cure can not be expected until the development of the larger medullary cavities of the bones is completed. Under appropriate treatment the disease is so far kept under control, that all suffering abates and disappears, at the same time that the general system remains in an unsatisfactory state. Of such cases a reasonable hope may be held out that the disease will be entirely cured by the twenty-first year.

Treatment.—The details of the treatment may be embraced under the following heads:

1. Removal of the obstruction of the discharges and the reduction in size of the swollen membranes.
2. The applications of mercurial ointment to the vestibule.
3. Straightening the nasal septum and overcoming atresia.
4. The administration of general tonics, etc.

(1.) The removal of the daily accumulation of the discharge in the nose and the naso-pharynx is a matter of great moment. If the discharge is in the nose it may be removed by dropping into the nose by a pipette (the head being thrown back) a few drops of a detergent lotion. In a short time the fluid is felt in the throat. It is very gratifying to notice the prompt relief which follows the judicious use of such remedies to the nasal mucous membrane, particularly if the medicine be allowed to trickle in small quantities along the lower border of the inferior turbinated bone.

When a mucoid discharge collects in the naso-pharynx, it is best

removed by the use of the pharyngeal syringe. The instrument used should be smaller than the one sold under this name. An instrument of convenient form can be improvised by attaching an Eustachian catheter to the nozzle of a No. 1 India rubber syringe, or to the smaller syringe used by dentists. The rule should be subject to no exception that the liquid is to be placed above the palate with the greatest care and gentleness, and a very small quantity, not over twenty to thirty drops, of the liquid thrown in. After the instrument has been withdrawn, the head is bowed and the fluid is invited to flow through the nose and to trickle from the nostrils. A child who has had the instrument used with violence will never consent to a second application. It must be remembered that the naso-pharynx in the child is very small, and becomes reduced to a mere chink when constricted, as at the time of the introduction of the nozzle of the syringe. The fluid thrown in can not return into the oro-pharynx, but must flow forward. Should force be used, by sending into the chamber a larger quantity of liquid than it can retain, and obstruction be present in the nasal chambers, the fluid will be exceedingly apt to pass up into the ears. Too much stress can not be laid upon this source of danger; for, with the general disuse of that dangerous instrument, the nasal douche, in children, the impression is received that the pharyngeal syringe is a safe substitute. It is, in the writer's judgment, but little less dangerous than the douche; indeed, the source of the danger to the ears is precisely the same in the two intances. No doubt the physician *can* use the douche without danger, as he can the syringe; but if he habitually uses an instrument from which no aural complication can possibly arise, he is then, and then only, absolutely safe.

A few moments after the first application, or toward the close of the first sitting (the handkerchief having been used by the child), large quantities of mucus or muco-pus are removed, and the little patient is made relatively comfortable for a period extending from several hours to a day. Any detergent, dissolved in tepid water, suffices for the purpose of making these applications. No specific action of drugs is to be anticipated. Weak solutions of carbolic acid and glycerine, namely, about one drop of the acid to two drops of glycerine, dissolved in an ounce of water, is as good as any. Boracic acid, in almost any strength, common table salt, and potassium chloride are all in use with physicians, and are found efficient. It is not so much the remedy selected, but the manner of using it, that should receive attentive care. The use of astringents so universally mentioned, such as the preparations of tannin, of zinc, etc., can be, in the judgment of the writer, discarded. As for the preparations of iron, they are, without exception, mischievous.

(2) The condition of the floor of the nasal vestibule almost always demands attention. The use of mercurial ointments, such as are employed by oculists for blepharitis and granular lids, is followed by most

encouraging results. The ointment of the red oxide of mercury in the proportions of one grain of the salt to one drachm of cosmoline is well borne. The ointment is best applied with a camel-hair brush to the interior of the nostril before retiring. An occasional application in the office to parts not accessible by an untrained hand is advantageous.

(3) The operations for misplaced nasal septum present no peculiar features in children, and the consideration of the procedures need not be undertaken here.

(4) In order to correct the discharge which is apt to be of a simple character, it is necessary to care for the general health.—The extent to which the tonsils should be reduced in size is to be determined by the degree in which they obstruct respiration. Should the premises given above respecting the etiology of the affection be accepted, it is evident that the tonsils need not and indeed should not be excised unless they are known to interfere with respiration, in which event they should be removed without hesitation.

Society Reports.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Stated Meeting, November 8, 1883.

The President, Dr. J. Trush, in the Chair.

Dr. Thad. A. Reamy reported the following case (see page 57) of

Posterior Section of the Uterine Cervix in a Virgin, for Dysmenorrhea, followed by Serious Nervous Symptoms.—Relieved by Trachelorrhaphy.

DISCUSSION.

Dr. Miles said that the paper just read forcibly illustrated the condition we find in so many girls before they have attained their full vigor. Nearly all these cases are suffering from anæmia and a highly irritable state of the nervous system. We may in some cases find abrasion or ulceration of the os uteri. These conditions can all be overcome by tonics, change of residence and proper hygienic measures.

He agreed with the sentiment expressed in the paper, that in the vast majority of cases health could be restored by judicious constitutional treatment alone.

Dr. Carrick considered this case a caution against meddlesome surgery. He believed that more harm had been done since the introduction of the speculum and probe than ever before. Caution should be urged against their too active employment.

Dr. Edward Mitchell had been present at the operation and was struck

with the peculiar appearance of the os. It looked as though a wedge-shaped piece had been taken from the posterior lip of the cervix, but whether this condition had been brought about by the contraction of the parts after section or not, it was impossible to say. The case was interesting from the fact that trachelorrhaphy was required in a nullipara.

Dr. Wenning thought that, concerning the case under discussion, the members of the Society were all of one voice. The results of a trachelorrhaphy in the vast majority of cases are so evident that the operation really admits of no discussion. But it is equally evident that harm has been done by the operation of discision of the cervix, so that it has grown to be a question whether section of the cervix is productive of as much good as has been accredited to it in the past. Obstruction to the menstrual flow is not now considered so frequent a cause of dysmenorrhœa as formerly, but that there is such a form he thought no one could for a moment doubt.

Dr. Cleveland said he did not desire to discuss the case reported to the Society. The operation, as reported, recommends itself, and what he had to say would be on the general subject of trachelorrhaphy. He spoke with diffidence in discussing the subject, because he had not yet performed the operation, but he thought it was quite probable that it would follow the same evolution that the section of the cervix had, undeservedly popular at first, then fall into disrepute, after a while finding its true level—viz., a valuable measure in a few properly selected cases. That the operation of trachelorrhaphy has been abused can hardly be denied, nor will anyone deny but that in some cases it relieves and even cures the patient of the chain of symptoms for which the operation is performed, but it is hard for one who is in the habit of observing the condition of the womb in child-bearing women to believe that this operation is required as frequently as most of the specialists would lead us to believe.

How often do we see women with badly torn cervices that pass life apparently without any inconvenience and are fruitful, in fact laceration is very frequent and it is not often you see the cervix of a multiparous woman that is not more or less torn. Among the women that I see it is seldom that I meet a case that I think calls for an operation. An incident bearing upon this subject which I will relate illustrates how easy it might be even in this operation to mistake the post for the propter. A patient of mine, the mother of one child, had a badly lacerated cervix, her child was a year old and she had never been restored to her usual health after the birth of her child. She had leucorrhœa, uterine enlargement, tenderness over the ovaries and pelvic neuralgia. Here, I thought, was a suitable case for operation and I prepared to operate, but when the time approached the patient declined to be operated upon. She was put upon tonic treatment, and electricity was used two sittings a

week of the constant current. She began to improve and entirely recovered in spite of the torn cervix. Now, if she had been operated upon she would probably have recovered all the same and the case would have been recorded as a case cured by trachelorraphy. I have no doubt but that in many cases reported as cures, the operation is really of secondary importance, if not positively harmful, while the improved management and careful treatment of the patient while she is under the charge of the physician is the real agent of cure.

Dr. Miles said in reference to the operation of trachelorraphy for conditions as described by the essayist, if the last speaker could see numbers of such patients, he would see the justifiableness of the operation. We do see a great many lacerations which are repaired by nature. If upon examining a patient we find the uterus in a normal condition and no cicatrical tissue in the cervix, such a case may clear up under a tonic course of treatment. But where we have a large amount of cicatricial tissue, where the uterus is hard and firm, the lips of the cervix rolled out on each side, and the whole aspect such as to almost make us believe that it is with cancer we have to deal, it is in these cases that trachelorraphy is so plainly indicated and where we get our most brilliant results.

He had had a case three years ago that forcibly illustrated the good results of trachelorraphy; where the patient had suffered from lacerated cervix for seven years and was not able to ride an hour without pelvic pain and prostration following. He removed the cicatricial tissue, closed up the rent, and she made a good recovery, afterward bearing other children and sustaining no laceration. Where we find this cicatrcial tissue our patient will never be well until it is removed and the laceration sewed up.

Dr. G. S. Mitchell remarked that on the subject of dysmenorrhœa there was a great diversity of opinions. Barnes, who associated the conical cervix with this condition, thought the difficulty lay at the os externum, while Sims held that the obstruction lay at the os internum. Both advocated section of the cervix.

The probabilities are that dysmenorrhœa has for its origin the condition of the menstrual fluid rather than a mechanical obstruction. The disintegrated blood and mucous escaping from a cervical canal perfectly pervious throughout may still be accompanied by severe pain.

As to the propriety of making the operation of trachelorraphy, any one who had seen any number of cases could hardly doubt its value. He had made the operation himself a number of times and had witnessed it over two hundred times and he had yet to see a case operated upon in vain.

Dr. Wright said there was no doubt from the history of the case presented by the essayist of the evening, that the operation of trachelorraphy was perfectly justifiable. He did not intend to offer any criticism,

but arose more for the object of dissenting from the views expressed by the last speaker. He was unwilling to admit that most cases of dysmenorrhœa were obstructive in their origin, but was of the opinion they were the exception. There were very few physicians but had cases of dysmenorrhœa under treatment, and he was satisfied the verdict was that either neuralgic or rheumatic conditions lay at the base, and that the larger per cent. of cases were benefitted if not cured by constitutional associated with local treatment, but generally the former. Obstructive causes undoubtedly existed in some cases, but they were in the minority, and he thought the cases few and far between, that required operative interference. As a matter of course, in such a case as described by the essayist, no cure could be anticipated. except by trachelorrhaphy.

Dr. Mitchell replied that he had been misunderstood. He did not state that he believed mechanical obstruction to be the cause of most cases of dysmenorrhœa. He had simply quoted the opinion of others.

Dr. Trush asked what the constitutional treatment was, if any, before the operation.

Dr. Reamy replied that tonics, baths, and electricity had been used, but that she continued to suffer pain, and was troubled with insomnia until after the operation.

Dr. Trush remarked that there was certainly this to be said in extenuation of the operation of incision of the cervix, in the case first reported, viz. that at the time it was done it was the fashion to make such an operation for a supposed obstruction in dysmenorrhœa. He hoped the reporter of the case would define the value and indications of the operation at the present time. It seemed to him that certain cases of dysmenorrhœa must certainly be obstructive in their nature. If those cases of flexion, such as we see figured in Thomas and Emmet, were not cases of obstruction, then he did not know where they were to be found. If the condition known commonly as pinhole os did not call for incision, then there were none that did.

Trachelorrhaphy at the present time was the fashionable operation, just as cervical division had once been, and like that operation it (trachelorrhaphy) was doubtless often performed when there was no real necessity for it. That however, in a certain proportion of cases of lacerated or divided cervix, like the one reported upon for example, it was imperatively demanded, he was ready to concede.

Dr. Jones remarked that it had been stated that a woman who has a lacerated cervix, cannot become pregnant. He could not agree with this statement. One case especially he could recall where laceration had occurred, the anterior lip becoming everted and very hard, and still the woman bore several children after the accident.

Dr. Thad. A. Reamy remarked, in closing the discussion, that he doubted the propriety of discussing the general subject of trachelorrhaphy

under the report of this case. He would not do so. He had made trachelorrhaphy in nearly two hundred cases, and had preserved notes of many interesting points connected with them, which he hoped at a future time to present to the Society. He had no doubt the operation is sometimes done in cases not demanding it. But no one could question its propriety in the case just reported. If any doubt had existed it was dispelled in the clinical fact that the patient immediately improved and speedily recovered of the distressing symptoms which had succeeded to the section of the cervix and the pathological and physical changes which followed it. A speaker had asked him what he regarded as the proper treatment for the so-called conical cervix. He could scarcely consider this question pertinent to the subject under discussion, unless in the opinion of his questioner the subject of this report had a conical cervix upon which the posterior section described had been made. He would assure the gentleman, however, that such was not the case, the section and its results could not have changed the typically conical cervix beyond his recognition.

He would answer the question briefly, but in doing so would beg to call attention to the well recognized fact that the conical cervix without hypertrophic elongation is a different condition requiring very different treatment in most instances from the so-called conical cervix with hypertrophic elongation. Many practitioners seem to regard the latter condition as a result or complication of the former, but this view is incorrect as to most cases. The pin-hole os, the stenosis confined to the os externum may be produced, and very frequently is, by the vicious use of caustics, more especially the nitrate of silver. The speaker had encountered very many such cases, but in these instances the conical shape of the cervix is not present. The true conical cervix is always congenital and stenosis of the os externum is in such cases invariable. But, as Barnes has pointed out, it is extremely rare to find stenosis extending to any considerable depth in the cervical canal in these subjects, at least not as a congenital condition. It may result in such subjects from complications or other pathological conditions, but is rare.

There is another state associated with the congenitally conical cervix, named in some text-books, but frequently overlooked as to its significance by the practitioner. He referred to the extraordinary firmness amounting almost to induration of the cervical tissue. These subjects are almost invariably the victims of dysmenorrhea; the menstrual blood being retained in the uterine cavity, coagulates and is expelled with great suffering. Ultimately, if unrelieved, endometritis, ovarian disease, and other pathological states may supervene. These cases are treated by forcible and persistent dilatation, or section, or incision, or amputation.

The speaker had in former years made posterior section in a few such cases, but has long since abandoned the practice. Forcible dilatation,

not by tents (for they should never be employed in such cases), but by dilating instruments; the practice being repeated month after month. Meantime the constant current, applied by carrying the cervical electrode within the cervical canal, had proven very satisfactory in his hands. He considered that electricity thus applied, in these cases, aids very much in securing two important results, upon which the permanency of relief largely depends. First. It lessens the induration of the cervical tissue. Secondly. Aids in the permanency of the distension secured by mechanical dilatation.

He had treated cases successfully by carying a narrow tenotome within the canal, to the extent of the stenosis, and making shallow incisions in different directions; then having the patient to wear, until the parts have thoroughly healed, the glass plug of Thomas. Incision should never accompany forcible dilatation, nor would it be followed by any permanent good unless the plug is also employed. He never amputates the cervix in these cases.

Hypertrophic elongation of the vaginal portion of the cervix is quite different from the above described pathological state. This may also be congenital, but the hypertrophic growth seems in many cases stimulated by chronic inflammation, which frequently attends these cases and induced by mechanical obstruction to the circulation. The speaker had seen several such cases where the lower portion of the cervix rested upon the hymen bulging it outward. He had seen one case protruding for a half-inch beyond the vulvar opening.

Emmet almost denies the existence of infra-vaginal hypertrophic elongation of the cervix. The speaker had great respect for the opinions of this distinguished author, but in this instance he must unqualifiedly dissent.

In cases where the fornices are found normal in position and form, the fundus of the uterus upon bimanual examination to be at its normal line, and by rectal examination that portion of the uterus above the vagina found to be normal in size and length, there can be no doubt as to diagnosis. In some such cases there is no thickening, either of the vaginal or cervical mucous membrane, and no stenosis of the cervical canal at any point, but there is often some narrowing with the conoidal cervix and pin-hole os. In these cases amputation is the only remedy worthy of consideration. As to the method, he considered that of Sims generally preferable to all others. It is the one he usually adopts, although he sometimes makes the flap amputation or wedge-shaped incision of the lips after Simon.

He supposed it is known to all that Sims uses the scissors, makes the amputation circular, glides the vaginal mucous membrane over the stump and stitches it except over the os, securing healing by first intention. The ecraseur and galvanic caustic wire might be considered in amputa-

tion of the cervix for cancer, but should never be employed for amputating the cervix in the cases under consideration.

The number of cases justifying amputation is much smaller than seems generally to be appreciated. With a much larger experience he makes the operation more seldom than in former years. Great care should be taken to see that the stump is completely covered at the time of operation by the mucous membrane, so as to prevent healing over in part of the surface by granulation, thus preventing the danger of cicatrization, an evil which may prove serious in its influence upon imprisoned sensitive nerves. Sims had made the discovery of this method of covering the stump by accident, but his wonderful ingenuity and originality had utilized it and made it a most valuable contribution to this department of surgery. Care must always be taken to avoid cicatrization or contraction about the os after amputation. The speaker had knowledge of two cases where pregnancy had followed amputation, although he believed sterility to be the general rule.

In answer to the inquiry whether, in his opinion, electricity would contribute to the reduction of the elongated cervix? he would answer emphatically no, notwithstanding, as he had already stated, this agent would aid materially in removing the unnatural density of structure found in the conoidal cervix, with the pin-hole os in cases where there is no hypertrophic elongation. He had found this agent of marked value in the development of the cervix in cases of congenital non-development. Here, however, the interrupted current is the proper one.

In reply to criticisms which had been made, he would say that dysmenorrhea is unquestionably sometimes due to mechanical obstruction. The pin-hole os is an example. He had likewise seen a few cases in the nullipara where the most painful menstruation had been completely relieved by correcting a sharp ante-flexion, allowing the patient to wear, for a few days prior to menstruation, a stem pessary; subsequently, for more permanent relief, using an ante-version pessary. On the other hand, he had witnessed numerous cases of both ante-flexion and retro-flexion, both in the nullipara and multipara, menstruation occurring without serious suffering. These cases, however, do not prove that these displacements may not cause dysmenorrhea. Undoubtedly they do. But the exceptions are sufficient to warrant extreme caution and to condemn the recklessness that would subject every woman who has dysmenorrhea to the knife or scissors.

The speaker must ask pardon of the Society for protracting his remarks far beyond the limits intended, also for covering by them a field he had not anticipated and omitting much he had intended to say, but his course in the matter had been determined by the remarks of members to which it seemed proper he should reply.

Stated Meeting, December 13, 1883.

The President, Dr. J. Trush, in the Chair.

PARENCHYMATOUS INJECTIONS INTO THE CERVIX UTERI.

Dr. Julia Carpenter opened the discussion by stating, she was interested in a short report on this subject in the *Medical News*. It was a translation from the *Berlin. klin. Woch.* July 2nd, 1883, of an article by Dr. Adrian Schuecking. She gave the following brief recapitulation of his method.

After placing the speculum and fixing the cervix, he forces into one of the lips of the cervix a long syringe needle.

Both before and after the injection the cervix is washed with some disinfecting solution. He has never seen any bad results follow this treatment, and has used it instead of the subcutaneous method.

Immediately after the injection the cervix becomes pale and smaller.

His reported successful cases were as follows:

1. Four, of uterine fibroma, when after about twenty injections there was either a diminution in the hemorrhage or size of the tumor, or both.

2. Puerperal subinvolution, causing prolapse and retroflexion. Injections were made, three times a week, of half a syringe full of diluted Fowler's solution, (one to three of water). After about fourteen injections the uterus regained its normal position.

3. Erosions with hypertrophy of cervical glands eight cases. Injections were made of tincture of iodine, and the cervix at the same time touched with pure active acid.

4. One case of exudation into the broad ligaments.

The speaker thought before trying this method she would like to know the opinion and experience of the profession at home on the following points, viz. In what class of cases they would consider it useful, what medicines they preferred in each, what doses, how frequent the injections, and whether they considered the treatment equally safe at the office or house.

DISCUSSION.

Dr. Wright said he had had no personal experience in this method of treatment, but had read a number of articles in the journals, and thought that in such cases as cancer, where you get the local action of the drug on the cancer cell, it would be of great value.

Dr. Palmer said he had not had an extensive experience with parenchymatous injections into the cervix uteri. It is however, a method of treatment, which, in a limited way, had been used for some years, and its use had been referred to by different members of the Society. *Dr. Miles*, he remembered, had given some experiences with it in fibroid tumors. As for himself, in this disease, he much preferred the method by subcutaneous injection, the favorite seat for injection being the abdominal wall, within three inches of the umbilicus, as he had found that, here, the injection in-

convenienced the patient less than others. Rarely did any inflammation or abscess follow. He had experienced some very good results in this way.

One advantage might be claimed for the intra-cervical method: it is less painful. But so far as the effect, by contracting the uterus and the tumor, diminishing their vascularity, is concerned, there was no advantage in it. Ergot or ergotine acts on the nervous system by absorption. Through the nervous system, it produces contraction of the unstriped muscular fibres, wherever found. Its absorption is not more thorough through the cervix, than through the abdominal walls. And when we consider that we are laboring under the disadvantage of the introduction of the speculum, the possibility that the flow of blood by the puncture may wash out the injected fluid, and finally that, a less quantity of fluid can be injected into the cervix than into the abdominal walls, we must conclude that, all things considered, parenchymatous injections in to the cervix for fibroid tumors is a method inferior to the ordinary one.

In *sub-involution* and *chronic metritis*, where there is great vascularity of the tissues, and subsequently, proliferation of the connective tissue resulting, ergot, in whatever form or way, whether per orem, per rectum, or subcutaneously, is an agent for great good. But for the foregoing reasons, he could see but little advantage in the method by cervical injection even in these diseases.

If there should be any co-existent para-metritic inflammation, these punctures into the cervix would probably be a source of irritation, and do harm. Certainly, he would hesitate some time before injecting solutions of iodine into the para-metrium, for the purpose of favoring absorption of any inflammatory exudations within these parts.

Nor, did he believe that *iodine* injections into the cervix itself, would prove of any special service in chronic metritis. We cannot effect any absorption of the hyperplastic connective tissue. All we can do is to control the hyperæmia, and at that point, the proliferation may cease. Iodine, as a topical agent, painted over the cervix, is a useful remedy in this disease, mostly, in as much as it improves the endometrial complication almost always found. Besides, it is revulsive in its action.

But there is a class of cases, in which this method of local treatment, may prove to be especially beneficial. These are cases of cancer of the cervix. Dr. Palmer said he had used carbolic acid in weak solution in this disease, and it had mitigated the pain. Beyond that, he was not yet prepared to speak. Possibly it may, in addition, prove to be of signal service in arresting cell proliferation—extension, and in effecting sloughing of the cancerous infiltrations. Time will soon demonstrate this.

As to whether these injections should be administered at the physician's office or the patient's house, he could see no special risk in ordinary cases, in making them at the former, or, little more than in the slight operation of puncturing the cervix.

Dr. Trush said he could not recall ever having employed parenchymatous injections of any kind, other than anodyne, into the cervix: Respecting the use of ergotine the subcutaneous method upon the abdominal walls, as described by Dr. Palmer, had proven so satisfactory in the class of cases mentioned that he could not wish for a better mode of treatment. The pain was not excessive, he had had no abscesses form, and the superior convenience, over the cervical mode, was unquestioned. As the remedy acted through the nervous system, no speedier or better action could reasonably be expected from its cervical injection, than from its subcutaneous application in other parts of the body. The anodyne injections into the cervix, alluded to,—morphia and atropia—he had made for rigidity of the os, as recommended by Ahlfield, and had obtained the desired result, but he was disposed to believe a similar effect would have been produced had the anodyne been injected elsewhere.

Those agents on the other hand which had a purely local action, as for example acetic acid, recommended by Broadbent in cancer of the cervix, these of course, must be injected into the diseased part. But the existence of a parametritis would forbid, he thought, the cervical employment of any and all irritating agents, ergot not excepted, for if thus employed on the presence of the extra uterine inflammation the latter would almost certainly be aggravated.

Dr. Carpenter remarked that it had been the experience of those persons who had written on this subject that the depletion caused by the puncture had been of advantage, and in spite of the small flow of blood, in the injection of iodine a metallic taste was soon observable. Also that the results of this treatment showed the medicine must have been retained at least in part.

She described a case of a nullipara 35 years of age of delicate constitution who had two fibroid growths on the posterior wall of the uterus, one the size of a hickory nut the other about half so large. The patient had come to her for other ailments, these growths at the present time giving her no uneasiness whatever. They were growing however, and it had been a question with her, whether they should be let alone until some discomfort manifested itself, or whether an effort should be made to remove them at once.

Typho-Malarial Fever in Pregnancy.

Dr. Wright reported the rather singular coincidence of having under his care at the present time three pregnant primipara, residing in different sections of the city, all suffering from typho-malarial fever. They were advanced respectively two and a half, four, and seven months. The disease began in all three as malaria and afterward took on the typhoid character. There were no enteric symptoms.

Dr. Cleveland remarked that he thought the profession was considerably mixed up in the diagnosis of typhoid and malarial fevers. Quinine, which

is the touchstone in malaria, had no effect in the so-called typho-malarial fevers. Nor was every case of typhoid fever attended with tenderness of the abdomen and diarrhœa. Constipation was not of unusual occurrence, and that those cases in which it existed were cases of typhoid fever had been proved by *post mortem* examinations of Peyer's patches.

He thought these cases of so-called typho-malarial fever were really mild typhoid fever masked, whether they existed in the pregnant or non-pregnant condition. He thought Dr. Wright's cases a rather singular coincidence.

Dr. Palmer thought that Dr. Wright's cases were merely a coincidence. It will be interesting to watch the condition of the infants at birth, and subsequently of these women, now pregnant and suffering with typhoid fever. He had recently delivered at term a seemingly healthy child, whose mother had had typhoid fever in early pregnancy. Her recovery was complete. The infant soon began to show evidences of ill-development of the brain, and is now completely idiotic. To his mind there was no doubt in this case a direct relationship of cause and effect between the typhoid fever in pregnancy operating on the fœtus, and the imperfect cerebral development of the child.

Dr. Gustav Zinke remarked that he also had in care a case of typho-malarial fever in a pregnant primipara about seven months advanced. She began with chills every evening, but coming on earlier every day. At the time he first saw her she had a daily chill about 11 a.m. He put her on fifteen-grain doses of quinine at 7 a.m., and her condition began to improve; but the pains in the back, of a bearing-down character, warned him of the danger of a premature labor. The quinia was withdrawn, and about this time the fever changed from the intermittent to the continuous type, the temperature ranging from 100° to 103–4° F. He was afraid to return to the large doses of quinine because of its effect upon the uterus. He put her upon the use of a placebo to see if the intermittent character of the fever would return, but the temperature remained the same. He then administered a mixture consisting of equal parts of tinct. ferri pomati and liq. potass. arsen., of which patient commenced to take gtts. v, three times a day, the first day, increasing the dose gtt. i each successive day, until irritation of the stomach became manifest, then receding in the same manner till irritation had subsided, and remaining at that dose (gtts. v in this case) till recovery had taken place. Duration four weeks; recovery perfect. Since then he had tried this remedy, with equally satisfactory results, in other cases of continuous fever, in which either the quinia was not borne well, or that it did not have the effect for which it was given.

Amputation for Excessive Hypertrophy of the Cervix.

Dr. Palmer reported a case of excessive longitudinal hypertrophy and elongation of the infra-vaginal cervix.

The patient was a colored woman, aged from thirty-five to forty. The hypertrophy was so great that the cervix extended from its ordinary position above, through the vagina, and protruded from an inch to an inch and a quarter exterior to the vulva. The region of the external os and the infra-vaginal face was enlarged, so that the whole cervix resembled the penis with its glans. The upper portion was very vascular, and to touch, throbbing blood-vessels were distinguished within its walls. The uterus proper was enlarged, but still in the pelvis; the enlargement being mainly in the posterior wall, and due to an interstitial fibroid.

For years this patient was compelled, at periods each of weeks, to abandon work and go to bed, on account of metrorrhagia. The hypertrophy was of years' duration. Patient was sterile, for coitus was impossible.

Amputation was made with the scissors. Assisted by Drs. Zinke, Percival, and McKee, the cervix was drawn down and a firm band of rubber placed around it, high as possible at the vaginal vault. The cervix was then transfixed with silver wire in three places, the center wire penetrating the cervical canal. Transfixion was made in close proximity to the rubber band. The cervix was now split bilaterally, and cut off close to the silver wire, some *three inches* being removed. The vaginal and cervical mucous membranes were then stitched together after the manner of Hegar, fourteen stitches in all being used. Not a drop of blood was lost in the whole operation until the band was cut, when perhaps a tablespoonful escaped. It was practically a bloodless operation, the cervix being completely Esmarched. Considering the feeble condition of the patient, the vascularity of the upper cervix, and the fact that amputation of the cervix is one of the most bloody of pelvic oprations, he thought this method had much to recommend it in similar operations.

Amputation by means of the scissors for hypertrophy with elongation, whether congenital or acquired, was much to be preferred to the method by the cold wire (ecraseur), or the galvano-caustic wire. The former is liable to slip down and scalp the cervix; the latter encounters the danger of secondary hemorrhage. Neither makes as neat a job as the scissors.

To return to the patient, the stitches were removed on the tenth day, when union was complete, the cervix assuming a very good shape. There were no untoward symptoms at any time, and the patient has now passed some two months without any hemorrhage, menstruation being normal.

Amputation was made anteriorly, as near the vaginal vault at its junction with the bladder as it was possible to extend it. This was done for three reasons: to remove the offending elongation; to effect better drainage of the uterus; to influence, secondarily, the fibroid enlargement in the body of the uterus.

Dr. Gustav Zinke said he had assisted at this operation, and although he had seen Dr. Palmer do a great many operations, he thought this ex-

ceeded in neatness and dexterity any ever done before. The cervix was so thoroughly removed and the parts so perfectly adapted, that very little hemorrhage took place when the hand was removed. Regarding the propriety, or rather necessity, of the operation, nothing need be said, since it evidently was the only measure which could possibly give relief.

Dr. Davy inquired if it was considered advisable to use the rubber band in all operations on the cervix.

Dr. Palmer said he did not use it in the operation for laceration of the cervix. Emmet, however, has used and recommended a uterine tourniquet of wire. But, ordinarily, all hemorrhage in trachelorraphy is easily controlled; moreover a moderate flow of blood is beneficial, softening the uterus, depleting from its congestion, besides being protective in its after effects.

THE MOST APPROVED TREATMENT OF INFANTS BORN AT SEVENTH MONTH OF GESTATION.

Dr. Gustav Zinke asked the opinion of the Society on the above subject. He had lately managed one something after the following plans: The infant was not washed in water, but with olive oil. It was then placed in a sheet of cotton large enough to envelop it completely, which was tied loosely at the neck, around the body, the thighs, and the feet. A shawl was then wrapped about it, and it was kept on a pillow. The cotton was changed twice daily, the bath of olive oil being given each time. The child received its nourishment from a wet-nurse, the milk for the first four or five days being drawn and fed to it with a spoon. At the end of that time it took the breast. The question might be asked as to how long this treatment was to be kept up. The child was now three weeks old and thriving.

Dr. Trush had had but one infant under his care so frail and minature as the one reported upon by Dr. Zinke. The little patient in question weighed a trifle less than three pounds; was extremely delicate, and utterly unable to nurse at the breast. The mother's milk was, therefore, drawn with a breast-pump, and fed to the infant from a spoon. In addition to this, the babe was placed in a bath of warm milk several times per day, in which it remained for fifteen or twenty minutes each time. No attempt was made for a full month to dress the child; but instead it was wrapped in fine cotton batting. It lived, and is now a well-grown young lady.

Dr. R. B. Davy reported

A CASE OF OBSTRUCTION OF THE BOWELS IN PREGNANCY.

He had seen this woman on Friday, December 7th. She was in the ninth month of pregnancy. After eating a hearty supper she had retired, and about 1 o'clock was seized with severe colicky pains and vomiting. He did not see her until 4 o'clock. He then gave her a hypodermic of morphia, and attempted to open the bowels with injections,

but was successful only to a slight extent. All the bowel below the obstruction was cleared out, but vomiting continued. The pain being in part controlled by the morphia, he hoped to prevent premature labor, but in spite of everything, on Sunday morning, the character of the pain never changed, and she was confined. He hoped, now, as she complained of no pain, that the obstruction had cleared away. At 1 p. m., however, of the same day, the pain grew worse, and the vomiting, which had ceased for some time, returned, and gradually assumed a stercoraceous character. Her condition now was very critical. On Tuesday there again seemed a slight change for the better, from the fact that less morphia was required. This improvement has proved permanent, and this evening she had a large and copious stool.

His idea was at the time of labor to introduce the right hand into the uterus, and with the left on the abdominal wall make a thorough exploration of the bowels. He was satisfied from the vomiting that the obstruction existed high up in the small intestine. He thought now that if he had done this, that he might have removed the obstruction. At the time of labor the case seemed so favorable he did not attempt it, and in the evening it was too late. After labor he explored the abdomen, but found no tenderness except at one point. On Tuesday he kneaded the bowels, and on the afternoon of that day he noticed the improvement.

ACADEMY OF MEDICINE IN IRELAND.

Obstetrical Section.

At the opening meeting, held at the College of Physicians, Dr. G. H. Kidd, President, occupied the Chair.

Dr. W. C. Neville, Sectional Secretary, read the minutes, which were signed.

The President's Address.

Dr. Kidd, the President, expressed his thanks for the honor paid him in electing him as President of the Obstetrical Section, the work of which during the past session he reviewed.

Sub-Mucous Fibroid Tumor.

Dr. Athill exhibited a sub-mucous fibroid tumor, globular in shape, almost the size of a turkey's egg, which he had removed from the uterus of an unmarried lady, æt. 35. The patient had suffered for more than two years from constantly recurring uterine hemorrhage, which had of late become almost continuous and accompanied with great pain. She consented only to a local examination when reduced to an extremely feeble condition. The uterus was then found to be completely filled by the tumor exhibited, which had been removed by the ecraseur, after dilating the cervix. The tumor was attached by a wide base to the fundus, but examination after its removal showed that it had been sep-

arated from the uterine wall by a distinct capsule, its connection with the uterus being maintained by a thin investiture of the proper muscular tissue of the uterus and of the mucous membrane which had become stretched over it during its extrusion from the uterine wall. Dr. Atthill emphasized the point that this was not therefore a polypus, properly so-called, which should consist of a continuous outgrowth of uterine tissue. There would be no difficulty in tracing the continuity of the uterine muscle into the substance of a true myomatous polypus, while the presence of a capsule causing discontinuity was characteristic of a true fibro-myomatous tumor. This distinction had been drawn by Paget, but had not been sufficiently attended to in current works.

Dr. Macan and *Dr. Kidd*, the President, dissented from the definition of a polypus as laid down by Dr. Atthill. They understood by a polypus a tumor possessing a pedicle, other considerations being immaterial and having no effect on treatment.

Uterine Polypus.

Dr. Macan exhibited a large uterine polypus which he had removed from the vagina of an unmarried woman, æt. 45, who had suffered severely from hemorrhage for twelve years. The tumor had passed into the vagina, being connected with the uterus by a very thin pedicle which, however, bled very profusely on being cut across by the ecraseur. The size of the tumor, the great length of the vagina, and the rigidity of the external parts, made the removal of the tumor very difficult, and in effecting it a rupture of the posterior vaginal wall into the rectum had occurred. The rent had then to be stitched, and the patient was doing well.

Dr. Atthill observed that this case was an exception to the rule that polypi when they had become vaginal rarely caused much hemorrhage.

Dr. MacSwiney inquired whether means might not have been employed to lessen the size of the tumor and so lessen the risk of vaginal rupture.

Dr. Horne observed that multiple incisions of the tumor had been successfully used to effect this purpose in similar cases.

Dr. Macan replied that in his patient the profuse hemorrhage which had followed the division of the pedicle had made it necessary to remove the tumor more rapidly than would otherwise have been desirable.

Macerated Twin Fetus.

Dr. Macan exhibited a macerated fetus which must have died about the sixth month of a twin pregnancy, the other twin continuing to develop until term. The surviving child, weighing seven pounds, was delivered naturally. Considerable hemorrhage ensued, and after the birth of the first placenta a degenerated placenta surrounding the second child followed.

Dr. Purefoy mentioned a similar case which had occurred in the Coombe Hospital.

Chronic Inversion of the Uterus.

Dr. Macan showed the fundus of a uterus which had become inverted nineteen years ago, after the only labor of a woman now aged 41. Since then she had suffered from severe hemorrhagia, and had been lately treated by pessaries for prolapse. The upper portion of the vagina was extremely narrow, and the vagina itself so rigid as to preclude the possibility of introducing a hand. He therefore determined on amputating the uterus, bringing the edges of the stump together by a number of sutures after the method advocated by him for the first time some years since in a paper read before the Dublin Obstetrical Society. The patient was able to walk about a week after the operation, her temperature never having exceeded normal limits.

Dr. Athill had found attempts to replace recently inverted uteri very dangerous, their tissues were so soft and lacerable. In one such case his fingers had gone right through the walls of the inverted uterus. When of long standing the inversion could be more safely treated; but reinversion might then prove of no great use. Amputation properly performed was certainly less dangerous than prolonged and forcible efforts at reduction.

Dr. Kidd, the President, had frequently practiced the operation as described by Dr. Macan, introducing the ligatures first, then amputating with the ecraseur, and finally bringing the surfaces of the stump together. He had never seen ill effects follow such an operation.

Induction of Premature Labor.

Dr. Purefoy read a paper on the induction of premature labor, illustrated by three successful cases. Having sketched the early history of the operation and the various methods employed, the author specified three classes of cases in which the induction of premature labor was indicated. Firstly, in the cases of women with pelvis so narrow that the passage of a living full-timed child is impossible, while an undeveloped yet viable child might safely be delivered. Secondly, where several previous successive pregnancies had been interrupted at a certain period by the children's death. Thirdly, where the women suffer from morbid conditions likely to disappear or become greatly mitigated by delivery. Difficulties arise in practice owing to doubts as to the exact period of pregnancy, and as to the true amount of pelvic deformity. The presence of deformity increased the difficulty of fixing the period of pregnancy, while the patient's own calculations are unreliable. The size of the child's head must be assumed from that of its known averages at different periods of gestation, while the available pelvic space must be carefully measured, as is often necessary, by the introduction of the entire hand into the vagina. In many cases the conjugate of the brim being the diameter

mostly if not entirely at fault, it will then suffice to measure this accurately. It is impossible to define narrowly the amount of pelvic deformity to which this procedure is applicable. But its extreme limit may roughly be stated to have been reached when the true conjugate diameter measures 2.75 inches. Dr. Purefoy then narrrated the history of three successive labors induced at the eighth month in a woman with a generally contracted pelvis, whose first labor had only been concluded by a difficult cephalotripsy, subsequently succeeded by a considerable amount of vaginal sloughing. The method adopted on each occasion consisted in the passage of a white elastic catheter between the uterus and the membranes, supplemented by the use of Barnes' bags. Delivery by forceps in each case resulted well for the mother and child. The author concluded that it is necessary, for the certain efficacy of Kranse's method, that the catheter should be so introduced as to reach the fundus uteri, otherwise contraction might fail to be set up. Caution must be exercised to avoid wounding the placental attachment. On each occasion he had found vaginal dilatation of much service in keeping up the uterine action. He did not doubt that the children's lives had been saved by the early application of the forceps, and before the os had been fully dilated.

Dr. Macan held that the chief danger in the catheter method consisted in the possible introduction of septic material into the uterus, against which every precaution should be taken.

Dr. Atthill could not regard the operation as an entirely safe one, having lost two out of five patients on whom he had performed it. The great danger was septicæmia. He had originally pointed out that the catheter must reach the fundus in order certainly to bring on labor.

Dr. Smyly remarked on the great difficulty of determining the size of the fœtus. Reliance could not be placed on the fact that craniotomy had been performed during two or three of the patient's previous labors. He considered a bougie much safer than a catheter, the latter affording a ready channel for the passage of air and septic material into the uterus.

Dr. Neville had assisted the President in three cases of induction of premature labor. The catheter alone had sufficed in each case to bring on labor quickly and quite successfully. He would by preference employ a bougie, and of course take every antiseptic precaution. All things considered, he believed Kranse's the safest method of inducing labor, and in his experience it had also been very speedy.

Dr. Horne had induced labor in two instances by this method; but one of the patients subsequently died of septicæmia.

The President having, he believed, tried most methods, held that the one under discussion was the best; rupture of the membrane being next best, though not so safe for the child. If the case were one that did not admit of delay, he would employ Barnes' bags. He did not consider it essential that the catheter should reach the fundus, as in cases in which

it had acted quite perfectly he concluded from its spiral shape on withdrawal that it had passed round the uterus between its lower segment and the membranes. He had only once used a stilette, and always softened the catheter well before using it. Labor usually came on within twelve hours.—*Medical Press.*

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting Thursday, February 7th, 1884.

The President, R. A. Cleemann, M.D., in the Chair.

A Year's Work in Ovariotomy.

Dr. Wm. Goodell read a report of his cases of ovariotomy during the past year. Of these he had twenty-five with seven deaths. Eleven of them were performed in the private rooms of the Hospital of the University of Pennsylvania with one death. Ten were operated on at their own homes with five deaths, and four at his private hospital with one death. He attributed the majority of the deaths to three causes: *First*, that he made it a rule never to doom a woman to certain death by refusing to operate on her however forlorn the hope of her recovery might be, and three of these fatal cases were very ill indeed at the time of the operation, from septicemia and purulent cysts. *Secondly*, That the women of this country being unwilling to go to a hospital, either insist on being tapped, which increases the risks of the radical operation; or else postpone the operation until the tumor has become very large, adhesions have formed and the health has become greatly undermined. Out of his twenty-five cases he had but eight without adhesions, and one of these, a case of double ovariotomy, died at home, he not having seen her or treated her after the operation. *Thirdly*, that five of his fatal cases had been operated on at their own homes, which were so distant that he was able to see but one of them after the operation, and she did not rally, but died in eight hours, from the shock of the removal of an intra-ligamentous cyst universally adherent. The fatal case at his private hospital was one of pelvic abscess bursting into the bladder. The operation was not a difficult one although the lower portion of the cyst had to be separated from the layers of the broad ligament by which it was enveloped. The sole fatal case out of eleven performed at the Hospital of University was due to hospitalism. This he deemed a good record for the building is used as a general hospital, with many railroad accident cases and suppurating wounds. In this hospital he always operated in one of the private rooms where the patient was kept until all danger was over.

While acknowledging that those results were not so good as those of British ovariotomists he said that on the other hand it was to be said in his favor that he never refused to operate on a woman however slim her chances of recovery. He made this statement, because according to a remark made

by Dr. Sutton at the last meeting of the American Gyneological Society, Billroth is the only one among European ovariotomists who "refuses to operate upon nothing that deserves the chance of life" and his success amounts to about 65 per cent, whilst one of the most successful of British ovariotomists "does not remove very large tumors, viz., those which weigh from sixty to sixty-five pounds, with extensive adhesions etc".

Out of the twenty-five cases of ovariotomy, there were twelve in which both ovaries were removed. In all these cases the second ovary was positively diseased. Yet with a large experience he (Dr. Goodell) was becoming more and more inclined to remove both ovaries in all cases of malignant degeneration of one ovary; in all women who have passed the climacteric or who are approaching it and in all cases complicated with fibroid tumor of the womb.

Finally he referred to the fact that some ovarian cysts, although they may appear to the eye benign, show from their subsequent history that they are malignant; the woman dying a few months later from carcinoma of the pelvic organs or at the site of former adhesions. Very unfortunately there are no diagnostic criteria to indicate the character of such a cyst.

Dr. A. H. Smith feels that Dr. Goodell is hardly right in saying that in England desperate cases are rejected. In his own experience, while in England recently, several cases which were very desperate, and which would have been generally rejected here were operated upon successfully and were ready for discharge three weeks after operation. It occurred to him that the lower average temperature had much to do with the result. The thermometer is not allowed to rise above 65° F. in the room in which the patient is kept; and in Lawson Tait's cases it rarely goes over 60°, and never up to 65°. Perhaps this has a good effect in preventing hyperpyrexia, The English ovariotomists are also very careful in details, especially in preventing hemorrhage, and use an immense number of hemostatic forceps. Ovarian cysts are remarkably common in London.

Dr. B. F. Dawson, of New York, upon invitation by the President, spoke of the English ovariotomists and alluded to what he had himself seen while on visits to England as to very desperate cases being operated upon. His own late experience had been so good that he was inclined to attribute it, as well as the good results of the English operators, to absolute pains taking in the most trifling details, with absolute cleanliness; not simply antisepsis, but the utmost care throughout every step of the operation. Among other things a very large number of hemostatic forceps are used to secure each bleeding point the moment that bleeding commences. His own last six cases of laparotomy, performed this winter, two of which were very desperate in their character, have been successful and the results, he felt were largely due to the avoidance of any preventable hemorrhage and great care through all stages of the operation to prevent blood

or fluid from the cyst escaping into the pertioneal cavity. This care is exercised throughout the "toilet of the peritoneum", and he always uses a flat sponge as does Mr. Wells inside of the abdominal walls, upon the intestines, while introducing the closing suture, which is removed only when it becomes necessary to do so to twist the last wires.

He always uses napkins to fold over the edges of the abdominal incision, to prevent the oozing from the edges escaping into the peritoneal cavity, or soiling the operator's fingers. He also enfolds the cyst in towels, as it is withdrawn from the cavity, to guard against even a trace of fluid soiling the intestines or wound. He clamps the pedicle temporarily when possible, and places a napkin under the clamp before dividing and cauterizing it. Every adhesion that shows any risk of bleeding is cauterized as soon as it is separated, even when ligated. Douglas' pouch especially is sponged out until the sponges come away absolutely clean. In a recent very desperate case, one in which Dr. Emmett expressed his sympathy with him as to its almost certain fatality, the operation occupied two hours and forty minutes, owing to painstaking observance of the above details; and, although half of the uterus was removed and adhesions were numerous, calling for many ligatures and frequent use of the cautery, yet convalescence was uncomplicated and speedy.

Dr. Goodell remarked that the quotation in his paper to which exception had been taken referred to Mr. Tait. It was taken from a paper read last autumn before the American Gynecological Society by Dr. Sutton, who was with Mr. Tait three months. He (Dr. Goodell) had seen about a dozen ovariotomies in Great Britain, and only one was a difficult case, and in that the patient died. There he had seen patients refused on account of their age, while in this country they are not. Dr. Goodell had operated successfully in patients aged respectively sixty, sixty-one, sixty-two, sixty-four, sixty-five, and sixty-seven years, and some one in this city had a successful case in a patient over eighty-three. Dr. Goodell had once operated upon a patient seventy-six years of age, of a long-lived family. This was before the days of antisepsis and the patient died. He believes that minute attention to details is the chief element of success. One important point is to make the abdominal incision sufficiently large to see every adhesion as it is separated, and to ligate or secure immediately every bleeding point. This requires a courage which it took him years to attain. He always observes Spencer Wells' method of placing a flat sponge beneath the abdominal walls when introducing the closing sutures. He does not like wire, but always uses carbolated silk sutures, each eighteen inches long. After all have been placed, the ends are twisted together in one strand on either side, and caught in the bite of a pressure-forceps. The lips of the incision are then widely separated, and a final search is made for any oozing, leakage, or accumulation of serum. They are then rapidly tied and the wound dressed. This final toilet of

the peritoneum can not be made when wires are used. He now believes in the use of a drainage-tube, but he had hard work to bring himself to the point of accepting it, as he still looks upon the tube as a foreign body, a necessary evil. He had once seen death caused in a healthy man by the simple perforation of the peritoneum, without wound of the intestine, by a small stilette, and this had made him fearful of the effect of the presence of a drainage-tube. But he considered that the peritoneum in the case of an ovarian cyst has, by thickening and attrition, lost much of its vulnerability, and does not resent slight causes of irritation. He occasionally resorts to the actual cautery at a black heat to stop bleeding from torn adhesions, but he prefers the pressure-forceps, the ligature, or the application of Monsel's solution. He thinks there may be some truth in Dr. Smith's idea concerning the effect of the low temperature of the operating and of the convalescent room. He was struck with the absence of ill-results in one operation in London by Dr. Bantock, of which he had been a spectator. The day was cold, damp, and foggy, and the operating room was chilly, the windows being open, but the patient promptly recovered. One case of his own, in which the extreme emaciation and prostration of the patient forbade postponement, was operated upon in severe winter weather; the steam-pipes at the hospital had been frozen over night, and, although they had been thawed out, the temperature of the operating room was only 54°. In this case the cyst had contained colloid matter, and had burst spontanously; all that could possibly be removed was scooped, sponged, and washed out. Much remained behind, yet the patient recovered and afterward became quite fat. This operation was performed three years ago; both ovaries were removed, but another tumor can now be discerned in the abdomen. The patient being fat, and also very sensitive, it is not possible to determine accurately its character; but he hopes it is a pedunculated fibroid of the uterus, and not a malignant tumor.

Dr. Dawson requested Dr. Goodell to give his opinion respecting the management of the drainage-tube, and of the importance of the spray.

Dr. Goodell, when operating in private houses, has begun to dispense with the spray. Carbolic acid spray poisons some patients, and he, being afraid of it, only uses it when he does not consider it safe to omit it—as, for instance, in a general hospital, or when there are many spectators present. Year before last he lost one patient from its use; she had contracted kidneys. Only last week, in a case operated on in the hospital of the University, the patient was profoundly affected by it, and was with difficulty restored by means of digitalis, stimulants, etc. When he omits the spray he uses the drainage-tube more frequently. If he finds in Douglas' pouch, after the sutures have been placed and the sponges removed, two or three drachms of bloody serum, and the source of this oozing can not be found, he inserts a drainage-tube; and he also uses it

in all cases in which there has been peritonitis, or when septic symptoms are present from a purulent cyst. Over the mouth of the tube he springs a piece of rubber sheeting, which is folded over a sponge squeezed out of a five per cent. solution of carbolic acid. The sponge is examined and squeezed out every few hours, and the tube moved slightly to clear the openings and allow any accumulation of serum to escape. As soon as a moderate amount of serum escapes without any tinge of blood, the tube is removed. This generally happens within forty-eight hours, but in one case it was necessary to allow it to remain five days. He never irrigates the abdominal cavity, but he sometimes introduces the long nozzle of a hard rubber syringe into the tube, and draws out any serum that may have accumulated. When he operates in the country and leaves the patient in the hands of the family physician, he tries to avoid the use of the drainage-tube as much as possible.

Dr. Dawson had given some attention to the question of the drainage tube. In New York two deaths had lately happened after ovariotomies, and in each case the surgeon had ascribed the fatal termination to the too early removal of the tube. Soon after these unfortunate cases he had operated and had been obliged to use the drainage tube; on the second and third days after the operation the serum exuding from the tube was bloody. On the fourth day it was pure serum. The patient was doing well and Dr. Dawson concluded to leave well enough alone, and, with the result in the two other cases before him, allowed the tube to remain. He used a wire with a pledget of absorbent cotton attached to the extremity, to soak out the accumulated serum, and continued to use fresh pieces until they came away clean. The tube was evidently being walled in by a deposit of lymph around it. On the sixth day, after finding very little serum, the last pledget of cotton brought away a little yellow spot that might have been either lymph or pus. That night he discovered another trace of the same appearance, and the microscope showed it to be pus. The next day the discharge was fetid. A salt-spoonful of iodoform was put into the tube every time it was cleaned and on the tenth day it was removed and a roll of absorbent cotton, saturated with iodoform was put in its place. This was replaced in a few hours with another until all signs of pus ceased. The opening closed in forty-eight hours. The patient recovered. He would like to ask if Dr. Goodell had ever regretted removing a drainage tube too early? Is a drainage tube more of a foreign body on the third or fourth day than it is on the first?

Dr. W. H. Parrish had recently performed abdominal section for the removal of a fibroma of the uterus. In this case he used a drainage tube although he was not able to pass it down into Douglas's pouch. On the third day he noticed that the serum escaping from the tube was cloudy and had a slight odor. On the fourth day the odor was quite objectionable and as the tube had evidently become separated from the abdominal

cavity by the formation of a canal of lymph around it, resembling in appearance diphtheritic membrane, he decided to draw the tube. He washed out the canal with a two per cent. solution of carbolic acid. The canal soon closed and there was no return of the offensive odor.

Dr. Goodell could not recall the loss of a case after the removal of a drainage tube. He has had, however, a number of deaths while the tube was still in position, but that meant simply that the cases were complicated and difficult ones. Was not the tube itself the cause of the pus in Dr. Dawson's case? Air, containing germs, was of course admitted into the tube in the cleaning out process, and these germs would cause decomposition of the lymph. Might not also the tube acting as an irritating foreign body cause pus? He introduces a stitch in such a manner, beyond the drainage tube, as to make tension of the skin around the tube, and this closes the opening as soon as the tube is withdrawn. He has occasionally followed the removal of the glass tube by the introduction of a rubber one of smaller calibre, but he has discontinued this practice, believing the glass tube to be the least irritating.

Dr. W. H. Baker reported for Dr. Walter F. Atlee a case of

ABDOMINAL SECTION.

Mrs. E. C., of Erie, Pa., was brought to this city by Dr. Edward Cranch. She was forty-five years of age, married, but had had no children. Her menses were regular and very abundant. She was a stout woman in excellent health. Four years ago she first noticed the tumor in the centre of the abdomen. Dr. Cranch reports that the probe enters the womb the normal distance only.

Diagnosis.—A multilocular cyst with thick walls and very glutinous liquid, or a fibroid tumor of the uterus. The sense of fluctuation was not distinct.

Operation.—February 4th, after the usual preparation, cut down, found a solid tumor, opened it, took out as much as possible of the contents, and got out the envelopes; the incision was about five inches in length. The tumor grew from the fundus of the uterus. It was transfixed, tied and dropped. The patient never rallied after the operation and died on the 6th of shock. There was no hemorrhage. The operation was all over in twenty-five minutes.

Dr. R. P. Harris saw the patient prior to and assisted in the operation. The lady had an appearance of health, was quite robust, and there was nothing in the contour or expression of her face indicative of ovarian cystoma. In a conversation with her sister and family physician, he learned that the diseased growth was first noticed by this sister, who remarked upon the central prominence of the abdomen of the patient who was at the time lying on her back on the floor engaged in playing with a little child. When the attention of the patient was directed to the fact that her abdomen presented a central elevation, even when flat upon

her back, she readily detected the existence of something abnormal. Dr. Harris remarked to the physician that the history of the case indicated the existence of a tumor at the fundus uteri. When the morbid growth was exposed it did not present the appearance of an ovarian cyst; neither did percussion indicate the presence of fluid prior to incising the abdomen, except by a surface wave. There was no wave transmitted from hand to hand. The surface wave was found due to some ascitic fluid. As no fluid escaped by tapping, the tumor was opened and its contents torn away in pieces, so as to reduce it sufficiently, when it was drawn through the wound, ligated at its union with the fundus uteri and cut away. During the shelling process a considerable loss of blood took place and the appearance of the patient was that of great prostration. The tumor had no pedicle, being sessile in its attachment to the uterus.

W. H. H. GITHENS, Secretary.

NEW YORK ACADEMY OF MEDICINE.

Meeting of December 6th, 1883.

THE PREVENTION AND TREATMENT OF PUERPERAL FEVER.

Dr. T. Gaillard Thomas read the following paper on the above subject:

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Let us pause here and review the features in the condition of the puerperal woman which render her a prey to so many and dangerous disorders which spring up as consequences of utero-gestation and of parturition.

In the first place, her blood is in a condition of hyperinosis—that is to say, it contains a great excess of fibrin. If it be drawn by the lancet, it presents the buffy coat, upon which our forefathers laid so much stress, in the most marked degree; and from this arise two liabilities—first, a tendency in this blood to form thromboses in the heart and the blood-vessels, and, second, a tendency to prove a most prolific ground for the development of sepsis and zymosis. Measles, scarlatina, and varioloid, which give no very bad prognoses when they excite zymosis in the blood of the non-pregnant woman, commonly produce death when they act upon the blood of pregnancy.

Then the nervous system is in a plus state of sensitiveness and excitability, and influences which are very controllable in the non-puerperal state produce very evil results here. For example, an accumulation of urinary poisons in the blood produces convulsions; an untoward moral influence produces violent mania; and crude ingesta result in severe spasmodic affections in the alimentary canal, which, in the same woman when not pregnant, would scarcely have attracted attention.

The local conditions which result from parturition are even more

striking. The uterus and other pelvic viscera are, at full term, as fully supplied by lymphatics and lymphatic glands as is shown in this diagram (here Dr. Thomas showed diagrams); and the arteries, veins, nerves, and other tissues of that organ, the vagina, the uterine ligaments, and the peritoneum have all undergone a rapid physiological hypertrophy, which permits of an organ only three inches in length ascending so as to touch the ensiform cartilage.

The uterus about the 280th day of gestation contracts and expels the child; then the placenta and membranes; and then closes its emptied cavity, and rests. Let us suppose that in forty-eight hours after delivery a primipara dies of pneumonia, and that we are allowed to lay open the genital tract and examine it from the fundus uteri downward. Outside all looks well; the uterus is merely larger than in the non-pregnant state. Within, it presents a very different appearance; the whole endometrium, covered over by the greyish, sloughy-looking decidua vera, presents all over its surface an unhealthy, unclean and diphtheritic look, although free from exudation. Here and there shreds of membrane, consisting of small portions of the decidua reflexa, which had become adherent, appear, partially detached and somewhat decomposed. At one point the large placental site is seen, raw, irregular, and covered over by minute traces of the placenta and small blood-clots which close the mouths of the uterine sinuses. The odor of the opened uterine cavity, the walls of which are thus covered, is disagreeable. The substances mentioned have for forty-eight hours been dislodging themselves and mingling with the pinkish fluid which pours like an unhealthy sweat from the placental site; constitute what is called the cleansings, or lochial discharge. Upon examining the cervix uteri, we find two or three small rents which pass through the mucous lining and involve to a varying depth the sub-lying parenchyma. In consequence of these injuries, and of absorption through them of the lochial discharge already mentioned, the cervix is swollen and œdematous. As we examine the vagina it will be found that the great distension impressed upon it by the head of the child in its passage to the vulva has in two or three places caused a superficial rupture of the mucous lining of this canal.

We now arrive at the vulva, and here we find several solutions of continuity which have been effected by the escaping head. The fourchette has been torn through, and this rent has extended through a small portion of the perineum, and one or two small fissures have occurred in the mucous membrane covering over the ostium vaginæ.

Were we to take some of the lochial discharge from the vagina, after the atmosphere has acted upon it, and, abrading the inside of the finger with a lancet so that it bleeds slightly, apply this freely to the denuded surface, and allow it to become dry there, its irritating character would soon become evidenced by a burning sensation in the part, a smarting

extending up the hand, and on the next day signs of a slight local inflammation, with a little lymphangitis, would be noticed. This would probably last only two or three days—merely long enough to demonstrate the fact that the fluid is an irritating one, but not sufficiently poisonous to cause erysipelas or severe angeioleucitis.

The natural history of the ordinary local results of human parturition is given in the foregoing sketch. In every case of child-bearing the endometrium is thus encumbered and freed by a process of exfoliation and sloughing; in every case the cervix, vaginal mucous membrane, perineum, and vulva are, in varying degrees, lacerated; and in every case the offensive fluid, called lochia, poisons these freshly made, unprotected wounds. And yet what are the usual results? Recovery, uniformly, I might say universally, unless some unusual occurrence manifests itself to prevent this happy consummation! Theorizing about the matter, one would suppose that the mortality resulting from such a state of things must be excessive. Here we have a number of recent wounds constantly and unavoidably bathed with a fluid made up of dead and decaying animal tissue in a woman whose blood and nerve states are, with reference to septic disease, like flax prepared for the spark, and who is exhausted by pain, anxiety, loss of blood, and deprivation of sleep. Can one point to any concatenation of circumstances better calculated to insure a bad result? And yet the facts are these: only about one or two in every one hundred parturient women ordinarily die when properly cared for during labor, even in the public hospitals.(1)

Recovery, then, is the very general rule after normal parturition; death the very rare exception. But now and then all this is changed. Some ferment or specific poison gains access to the genital canal and acts as rapidly and as decidedly as a little yeast added to dough. In the latter case, active and immediate fermentation affects the whole mass; in the former a set of striking, alarming, and often fatal phenomena occur, which spread dismay through the lying-in chamber and give an entirely new complexion to the progress of the case. The fact that this unfortunate occurrence has taken place will usually announce itself to the attending physician in this way. He leaves his patient on the morning of the third day, cheerful, happy, free from pain, with a pulse of 85, and a temperature of 99°. He is called to her in the latter part of the day, and finds that she has had a slight, perhaps a scarcely perceptible chill; that some pelvic pain has followed it; that the lochia have ceased, that the milk, which was just showing itself, has disappeared; that a severe headache exists; that a look of indescribable anxiety has replaced the happy expression of the morning; that the pulse rate is 130 to the minute, and that the buccal temperature is 104°.

1 Tarnier, "Report of Maternite Hospital," Paris.

A poisonous element has, by some method or other, reached the genital tract, as fruitful a field for its activity as a mass of dough is for yeast, and the result is already manifesting itself. Let us suppose that the patient's medical attendant lays the flattering unction to his soul that all this is due to "malaria"; or that he soothes his troubled mind with the hope that it is "milk fever"; or that, recognizing the attack as one of "puerperal septicæmia," or "blood-poisoning of child-bed," the first link in that terrible chain called puerperal fever, he relies upon medicines given by the mouth or rectum, what is usually the course shown as the natural one of the affection? Within a week or thereabouts—for there is no rule as to this point—parenchymatous metritis, lymphangitis, lymphadenitis, phlebitis, cellulitis, or peritonitis will very probably develop itself, and what was originally merely a septicæmia will merge into one of these affections, and the patient will pass through the perils attendant upon whichever of these pathological states manifests itself as a consequence of the initial lesion.

Sometimes the septic disorder develops the puerperal mania, while at other times a septic pleuritis, endocarditis, pneumonitis, pericarditis, or meningitis follows the systemic poisoning, the lymphatics emptying the deadly contents into the thoracic duct, and thus transferring them into the subclavian vein, as Lusk clearly points out. At other times the condition continues one of true and uncomplicated septicæmia to the end, death occurring from coma, or the patient succumbing to exhaustion from hyperpyrexia, which lasts for weeks. What was originally septicæmia, however, as a rule, rarely remains so, but generally passes into some other disorder, and very generally into peritonitis, before a fatal termination occurs.

And now comes naturally the question, What is the pathology of that affection styled puerperal fever? An inquiry into the views which prevail among others would evidently require more time than I can possibly allot to it to-night; and yet I am desirous that my answer, even if very short, shall be so clear, succinct, and simple as to convey perfectly the opinion which a practice of thirty years has impressed upon my own mind concerning a subject which has always deeply interested me, and in connection with which I have had abundant opportunity for study, both at the bedside and in the dead-house.

My observations have led me to adopt the views of those who believe that *puerperal fever is puerperal septicæmia.* It matters not whether it assume the form of metritis, phlebitis, cellulitis, peritonitis, or lymphangitis, the essence of the disorder is a poison, which is absorbed into the blood of the parturient woman through some solution of continuity, and which, in the appropriate soil of the puerperal condition, fructifies and produces the results known in its *ensemble* of pathological phenomena as puerperal fever. From my standpoint, the matter is well stated by

Lusk(1) when he declares that "it has now passed beyond the domain of dispute that puerperal fever is an infectious disease, due, as a rule, to the septic inoculation of the wounds which result from the separation of the decidua and the passage of the child through the genital canal in the act of parturition."

As early as 1870 Hervieux, in his work on the diseases of child bed, already alluded to, expressed himself upon this point in the following words: "Here I stand; if what I have said does not carry conviction of the truth of my doctrine, fuller explanation will fail to do so. I believe in the multiplicity of puerperal diseases. I believe in puerperal poisoning as the source of them. Here, in two words, my creed is presented."

In 1877 the Berlin Obstetrical Society appointed a committee on puerperal fever, consisting of Schroder, Lohlein, A. Martin Fasbender, and Boehr—men whose names are sufficient to command attention, even if their words fail to carry conviction. In its report this committee expresses its views thus:(2) "Under the names 'puerperal fever,' 'malignant child-bed fever,' are included a group of diseases occurring in child bed which vary very greatly in their manifestations, but have this in common, that they are called into being by the absorption from the organs of generation of a material which gives rise to destructive inflammation and fever. There are, indeed, a number of substances, mainly composed of organic materials in a state of putrid decomposition, which, when brought into contact with an open wound, set up inflammation in it, which extends to the neighboring tissues; a further absorption by the lymphatics and blood-vessels leads to more extensive inflammation among neighboring and remote organs; and, when a large quantity is rapidly absorbed into the blood, a quickly fatal poisoning of the whole organism occurs. To surgeons the deadly effect of these materials upon wounds is only too well known, and the greatest advance, probably, which surgery has ever made consists in the so-called antiseptic method of treating wounds; that is, in the scrupulously exact removal of such materials from fresh wounds.

"Puerperal fever is indeed nothing else than the infecting of fresh wounds, such as are found in every newly-delivered woman, with these destructive septic materials. Almost every woman, after labor, has small wounds on the external genital organs, which are caused by the passage of the child through this narrow opening, and in every newly delivered woman the inner surface of the uterus, from which the protecting membrance has been cast off with the ovum, presents a large wound surface. Thus, every newly delivered woman is liable to suffer from the dreaded infective wound diseases, which in persons wounded under other circumstances, are called pyæmia, septicæmia,

1 "Midwifery," p. 608.
2 "Report of Puerperal Fever Committee of Berlin Obstetrical Society," December 4, 1877, p. 9.

wound-fever, blood-poisoning, purulent infection, etc., *so soon as suitable septic materials are brought into contact with the genital organ.*" * *

What is the nature of this subtle and deadly poison, which, entering like a ferment into the genital canal of the puerperal woman whose blood is hyperinosed, whose nerves are in a condition of hyperæsthesia, whose utero-placental vessels are partially open, whose cervix uteri, vagina and vulva are covered with fresh superficial wounds, and whose womb is pouring slowly forth a fluid composed of dead tissue, decomposed blood and recently exfoliated cells, gives rise to so much disturbance? What do we know of the poison? what is its natural history? what encourages its life? and what kills it, or cripples its activity?

Unfortunately, these questions cannot to-day be satisfactorily answered; but have such questions been any more satisfactorily answered with reference to scarlatina, measles, and varicella? German pathologists have proved that the presence of micrococci, more especially of the round bacteria, occurs so frequently in the pathological products of puerperal diseases as to lead to the conviction that they are important factors in reference to them; but this point, like many others connected with the influence of bacteria as morbific agents, is yet too unsettled for admission into a practical treatise like the present.[1] Inquiry into the matter is now being pushed with vigor in the laboratories of France and Germany, and we have, according to recent reports, a fair prospect of valuable and practical results.

But, even although we do not at present know the exact nature of the poison which proves the disturbing element in these cases, we surely know that some such toxic agent exists, and it behooves us to learn how to prevent its entrance into the genital tract, and how best to destroy its life or its activity if it should gain admission in spite of our care and watchfulness.

Whatever be the character of this agent, we know that there are *two, and only two*, methods by which it can reach the parturient tract and exert its baneful influence. First, it may be carried to the vulva and into the vagina through the open orifice of that canal by the atmosphere, in which it floats as an impalpable substance; and, second, it may be carried to any part of the genital tract by the fingers of doctor or nurse; by towels or cloth laid against the vulva; by sponges used in washing; by instruments used in the delivery of the child, drawing of urine, or injecting the vagina; and from the bed-clothing and body-clothing of the patient which are in immediate contact with the sexual organs. * * * *

Prophylactic measures which should be adopted in all midwifery cases, whether they occur in hospital or in private practice:

1. The room in which the confinement is to take place should have the

1 In reference to this part of our subject I would refer those interested to the chapter upon it by Professor Lusk, in his masterly book upon the "Science and Art of Midwifery."

floor, walls, and furniture thoroughly washed with a ten-per-cent, solution of carbolic acid or mercuric bichloride, 1 to 1,000, and the bedstead and mattresses should be sponged with the same solution. Curtains, carpets and upholstered furniture should be dispensed with as far as possible.

2. The nurse and physician should take care that all their clothing, both under and upper, be clean and free from exposure to the effluvia of any septic affection. Should either of them have been exposed within a fortnight to the effluvia of such affections as scarlet fever, typhus, erysipelas, septicæmia, or the like, they should change every article of clothing and bathe the entire body, especially the hair and beard, with a reliable antiseptic solution; that which I prefer for this purpose is a saturated solution of boric acid.

3. As labor sets in, the nurse, having thoroughly washed her hands, cleaned her nails with a stiff nail-brush, and soaked them in antiseptic fluid, should administer to the patient a warm vaginal injection of antiseptic character; bathe the vulva and surrounding parts freely with the same; repeat this every four hours during labor; and keep a napkin, wrung out of the warm antiseptic fluid, over the genital organs until the birth of the child.

4. Before assuming the functions of their respective offices at the moment of labor, both doctor and nurse should wash the hands thoroughly with soap and water, *scrub* the nails with a stiff nail brush, and soak the hands for several minutes in a bichloride solution, 1 to 1,000.

5. The first two stages of labor having been accomplished, the third stage should be efficiently produced; all portions of placenta and membranes removed, and ergot administered in moderate doses three times a day, and kept up for at least a week, for the complete closure of the uterine cavity, expulsion of clots and occlusion of the utero-placental vessels.

6. The doctor, taking nothing for granted, not satisfying himself with a vague report of the nurse, should, at the conclusion of the labor, carefully examine the vulva of the patient. If the perinæum should be lacerated, it should be closed at once by suture, to shut up this avenue to septic absorption; and, should slight solutions of continuity be found in the labia or the vulvular extremity of the vagina, these should be dried by pressure of a linen cloth touched with equal parts of sol. ferri persulph. and carbolic acid, again dried thoroughly by pressure with the cloth, and then painted over with the gutta-percha collodion. If this be thoroughly done, absorption will be prevented at these points for at least three or four days, when the application may be repeated.

7. In six or eight hours after the labor, when the patient is rested, the vagina should be syringed out with an antiseptic solution, and a suppository of cocoa butter, containing from three to five grains of iodoform, should be placed within it, under the os uteri. A syringe with intermit-

tent jet should be used, which will wash away with gentle force all blood-clots, and reliance should not be placed on the feeble drip of the fountain syringe, the advantages of which are, I think, entirely theoretical.

8. These vaginal injections and suppositories should, in cases of normal labor, be repeated every eight hours; in cases of difficult or instrumental labor, twice as often; and they should be kept up for at least ten days, the nurse observing to the last the precaution already mentioned of washing her hands before every approach to the genital tract of the patient.

9. When catherization becomes necessary, it is safer to employ a new gum elastic catherer which before use should be thoroughly immersed in antiseptic fluid, and which should be destroyed at the conclusion of the case, rather than to trust to the nurse's cleaning of an old silver instrument which bears within it the register of a list of cases of septicæmia in which she has employed it during the past two or three years. *It is a very common and very bad habit for nurses to own silver catheters, which they carry about with them from case to case of midwifery.*

10. Last, but by no means least, let the physician inform himself by personal observation as to the competency of the nurse to syringe out the vagina thoroughly, to place the antiseptic suppositories where they should be, and to use the catheter without injury to the patient. Neglect of this precaution has frequently resulted in leaving a fœtid upper segment of the vagina entirely unwashed, while the antiseptic stream was limited to the lower third of the canal. * * * * * * *

Before leaving this part of my subject, let me, in the strongest manner, record my protest against the use of intra-uterine injections as a prophylatic measure, except after very severe operations within the uterine cavity, which render the occurrence of septicæmia almost certain. As a preventive measure, to be uniformly adopted, I look upon it as to the last degree rash and reprehensible. The use of a dangerous remedy in combating the results of a dangerous disorder is always admissible, but a resort to a hazardous procedure for a condition in connection with which danger has not shown itself, and may not do so, should be viewed in quite a contrary light.

Meeting of February 7, 1884.

The special order of this meeting was the discussion of the paper of Dr. T. Gaillard Thomas on "The Prevention and Treatment of Puerperal Fever," and was opened by the President, *Dr. Fordyce Barker*, as follows:

During the five years which I have had the honor to occupy this chair I have never before seen a meeting of this Academy so enthralled by the charm of elocution, the fascination of rhetoric, the glow of conviction, and the air of one who speaks by authority—an air which can never

carry weight unless it has been before fairly and justly earned by good work—as on the evening of December 6th, when the paper was read on "The Prevention and Treatment of Puerperal Fever.

Its authoritative tone, its earnestness and sincerity, its coloring of being based on experience and observation, instead of being unconsciously deduced from preconceived theory, give the paper such a plausible air of scientific truth as must secure its acceptance without question by many minds whose belief rests on authority, without examination of the data or analysis of argument. The more eminent the author of errors which may dangerously influence medical practice in matters of such vital importance as the saving of life of those who have just become mothers, the more striking the literary excellence and the more admirable the artistic merits of a paper promulgating such errors, the more necessary it is that such errors should be boldly met and promptly refuted. Any paper read before this Academy, by one to whom all concede a place among the most eminent in the department of the profession to which his life has been devoted, if allowed to pass without examination and discussion, will be accepted by great numbers in all parts of the country as a statement of the science and medical practice as enunciated by the most prominent men of the period. It is therefore a duty to carefully examine those novelties in doctrine and in practice which are brought here, and subject them to the test of the advanced science of the day and the accumulated experience of the past.

I will mention one other reason which has had a strong influence in overcoming my reluctance to do this work, and that is in the interest of the Academy.

In view of some past controversies outside of the scientific aims of this body, it seems to me desirable and important that the profession at large should understand that in this hall there can be the strongest antagonism in scientific doctrines and in questions of practice, and the keenest encounters in intellectual gladiatorship, carried on with all the courtesy of the duello, without individual hostility or the interruption of personal friendship.

I think most present know the great reluctance which I have to writing, especially the mechanical part—and that other engrossing work leaves me little time for this, except what should be passed either in rest or in recreation, and will therefore thoroughly appreciate the great reluctance with which I have undertaken the duty.

All will agree that the paper was remarkable for its originality, in that some of its pathological doctrines and the practice inculcated for the prevention and treatment of puerperal fever have never been taught in any work on obstetrics, or by any writer of acknowledged repute. If they are accepted by the common intelligence of the profession, they will assuredly be found in the obstetrical works of the future.

As there are many others who will take part in this discussion whom all will be anxious to hear, and as the author of the paper is entitled to all the time he may wish to close the debate, I shall, in the most concise language consistent with clearness of statement, give my reasons for thinking that the whole tone and coloring of the paper are misleading and dangerous, because it is supersaturated with septic infection. I would not "speak disrespectfully" of puerperal septicæmia. I believe it to be one of the most dangerous incidents which may occur to women after childbirth, and I trust that it will not be regarded as indelicate if I allude to the fact that in a work on puerperal diseases, published more than ten years ago, a lecture devoted to the consideration of this subject in all its relations fills thirty-seven pages. With the most anxious desire to correct any errors of opinion, and to accept any new views which progressive science or increased and more accurate clinical observation has demonstrated to be true, I have yet found no reason to make any essential change of the views expressed in that lecture.

In the paper which we are now to discuss the author distinctly avows his belief, without any qualification, that "puerperal fever is puerperal septicæmia," and that "it matters not whether it assume the form of metritis, phlebitis, cellulitis, peritonitis, or lymphangitis, the essence of the disorder is a poison, which is absorbed into the blood of the parturient woman through some solution of continuity." Not only the sentence quoted, but the whole tenor of the paper, must convey to the unbiased mind that it is the well-defined opinion of the author that metritis, phlebitis, peritonitis, and cellulitis are never seen in the puerperal woman except as the result of an initial lesion, which permits the absorption of a specific poison through the parturient canal, either from the atmosphere or from direct infection by doctors or nurses from neglect or carelessness, or other agents brought in contact with the sexual organs.

The tendency to this pathological view has been rapidly growing within the past few years, as a result of the enthusiastic interest excited chiefly by the important investigations of our German co-workers, who have so zealously studied the character and effects of the micro-organisms in puerperal women *in hospitals*. In several of the most recent and the most excellent systematic works on obstetrics I have observed that nothing is said of the various local phlegmasiæ which are liable to arise in puerperal women as a consequence of parturition, and that they are only alluded to in connection with the subject of septicæmia. This seems to me a very grave omission, which must seriously embarrass young obstetricians, who consult these works for information when normal convalescence is interrupted by any of the local inflammations. No one, as yet, has maintained that the process of parturition and the puerperal state exempt a woman from those causes which induce local inflammation in the non-puerperal, or will deny that the process of parturition, and other attend-

ant conditions besides the absorption of septic poison, may be the efficient cause of local inflammation; and I here state my conviction that in private practice, when there is no epidemic influence, twenty cases of local inflammation, due to such causes, will be met with where one will be found due to septic absorption.

It is hardly necessary to say, as I have before expressed the same opinions in a work published some years ago, that I am in entire accord with the author in his preliminary remarks as to the peculiarities in the system of puerperal women. I suppose that all educated men now know that the blood of a pregnant woman is in a state of hyperinosis, and that, as a rule, "her nervous system is in a plus state of sensitiveness and excitability, and influences which are very controllable in the non-puerperal state, produce very evil results here." But it is very evident that in certain points our opinions are wide apart. He regards certain conditions, which always are found following normal labor, and always occur in normal puerperal convalescence, as pathological, but which I believe to be purely physiological.

The ancients believed in the poisonous nature of the menstrual fluid. Pliny described the menstrual fluid as a "fatal poison—which corrupts and decomposes urine, deprives seeds of their fecundity, destroys insects, that it blasts the garden flowers and grasses, and causes fruits to fall from their branches."

I had supposed this superstition to be extinct until informed by a letter from my friend, Dr. Weir Mitchell, that he knew "old men who would not permit a woman to enter their wineroom, for fear that, if menstruating, it would injure their wines." He also informed me that "in Roquefort women are not allowed in their cheese cellars." I suppose the theory must be that menstrual bacteria will destroy the bouquet of the Roquefort cheese.

But on the evening of December 6, 1883, in this Academy of Medicine, I first heard the full evolution of this doctrine clearly enunciated. The lochia are described as an offensive fluid, made up of dead and decaying animal tissues, which poisons freshly-made unprotected wounds. I quote textually two paragraphs:

"In every case of child-bearing the endometrium is thus encumbered, and freed by a process of exfoliation and sloughing; in every case the cervix, vaginal mucous membrane, perineum, and vulva are, in varying degrees, lacerated; and in every case the offensive fluid, called lochia, poisons these freshly-made, unprotected wounds."

Again the writer says: "Here we have a number of recent wounds constantly and unavoidably bathed with a fluid made up of dead and decaying tissues, animal tissue in a woman whose blood and nerve states are, with reference to septic disease, like flax prepared for the spark, and who is exhausted by pain, anxiety, loss of blood, and deprivation of sleep."

Other quotations might be given of a similar tenor, and the prophylactic measures, which he asserts "should be adopted in all midwifery cases, whether they occur in hospital or in private practice," are based mainly on this theory.

Can it be true that the process necessary for the birth of the human race is always attended with the development of a deadly poison whose malignant effects must inevitably prevent the spontaneous and kindly healing of such little traumatisms as always result from the process, and that, therefore, it is the duty of the accoucheur to take preventive measures of the character proposed? Does every parturient woman, in performing the function of maternity, like the scorpion,(1) that carries in its tail an agent for suicide, if death is threatened by fire, physiologically generate an equally fatal poison in a corresponding locality, which the obstetrician must guard against by means that are most inconvenient, alarming, and not altogether free from danger?

I do not intend now to examine the question, which I have before discussed very thoroughly, and my views have long been published, whether there is not a distinct disease, most appropriately denominated puerperal fever, when, if there be any septicemia, it must be a consequence of a primary disease, and not a cause. Nearly a hundred years ago the eminent obstetrician of London who succeeded Denman, Dr. John Clarke, wrote as follows in regard to puerperal fever: "Unfortunately, the uniformity of the disease was assumed, and each author erected his own experience into a standard, by which to judge of the descriptions and the practice of others." This observation, which I read early in my professional life, made a strong impression on my mind. I trust that it will not be deemed egotistical that it had great influence on my mind during the twenty-five years that I was engaged in teaching medical students, as I felt strongly the responsibility of the position, and that I should be culpably negligent in my duty if I simply gave the results of my own observations, or the opinions of a limited number of observers, or the theories of a few popular authorities, but that I was bound to give the sum of the knowledge which had become a part of the common stock of the profession. For reasons which will be obvious, I felt this more

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1 The late Professor William H. Van Buren used to narrate that, when a surgeon in the army and stationed in Florida, he had often seen the soldiers amuse themselves by placing a scorpion within a circle of fire. After vain and frantic efforts to escape, it would stop, strike its tail into its head or body, and instantly die.

Byron refers to these insect Catos in the following lines:

"The mind that broods o'er guilty woes
Is like the scorpion girt by fire,
In circle narrowing as it glows,
The flames around their captive close,
Till, inly scorch'd by thousand throes,
And maddening in her ire,
One sad and sole relief she knows:
The sting she nourished for her foes,
Whose venom never yet was vain,
Gives but one pang, and cures all pain,
And darts into her desperate brain."

—*The Giaour*.

strongly in regard to puerperal fever than any other subject which I had to discuss either before medical students or in medical societies. More has been written on this than on any one disease. It has been a terribly fatal disease in lying-in hospitals in all the great cities where such hospitals are found. It has been fatal as an epidemic in rural districts, where within a certain area every woman in a sparsely-settled population, who gives birth to a child, for a certain limited period is affected, and a large proportion die. I could refer to very many published reports of such epidemics which have occurred in villages and towns where for twenty-five or thirty years previous not a single death has occurred in childbirth except from the casualities of labor, such as rupture of the uterus, hemorrhage and convulsions.

All we know of any disease is derived from the study of its etiology, its clinical phenomena, and its anatomical lesions. The epidemic disease to which I have just referred differs in all characteristic points from what is known as septicemia. It differs in its origin, its modes of attack, its symptoms, and its anatomical lesions. The symptoms are frequently manifested a day or two before or even during labor, even when the child is subsequently born alive. In septicemia the symptoms are never observed before or during labor, except when the fetus is putrid. The former disease, puerperal fever, originates from epidemic causes, and from contagion and infection. The latter, from nosocomial malaria, from autogenetic infection, and from direct inoculation. Can a woman after childbirth be exposed to the danger of receiving the poison which produces septicemia in larger doses than when she has retained in her uterus a portion of putrid, decomposed placenta? Yet I do not believe there is a single person who has had considerable obstetric practice for twenty years who has not had more than once to remove portions of putrid placenta which had been retained for days, and the patient has had no disturbance of such severity that he would call it puerperal fever. In the *Texas Courier-Record*, December, 1883, Dr. H. C. Ghent, of Belton, Texas, gives an amusing report of a case to which he was called three days after labor. She was attended during labor by an ignoramus, who appears to have used considerable force, and probably made some efforts to extract the after birth. The patient, before he left, called his attention to something like a cord protruding from the vagina, which he said would, perhaps, come away by piecemeal. On his visit the next day, he at first said that a protrusion from the vagina was a false conception, but afterward pronounced it a falling of the womb, which, after a considerable length of time, he succeeded in replacing, and had the anxious husband engaged for twelve hours in constructing an abdominal supporter. On the third day, Dr. Ghent removed a large portion of the placenta and membranes, a putrid mass, with a stench which "was about as much as an ordinary pair of olfactory nerves could well bear." The

patient had a quick pulse and high temperature, the constitutional disturbance was easily allayed, as it seems that a "few thorough washings with hot carbolized water" was all the treatment required.

Before leaving this part of the subject now under discussion, I will briefly allude to one other point, which strikingly illustrates the difference between puerperal fever and septicæmia. I think there can be no doubt that the majority of the profession believe that all those causes of nosocomial malaria, such as aggregation, bad ventilation, contact with septic material, etc., which have a tendency to induce septicæmia in surgical cases, have an equal tendency to develop the disease known as puerperal fever in women recently confined. But this does not prove that the diseases are indentical, for I think there is abundant evidence that, while these causes are always requisite for the development of surgical septicæmia, puerperal fever may be a very epidemic when these causes are wholly wanting.(1)

In the early months of 1873 puerperal fever prevailed in the best parts of the city, and in that class of society possessed of abundant means and living under as good sanitary conditions as are possible in any large city, to a degree and extent here unknown for the previous twenty-five years. The deaths from the disease in the hospitals and in the wards of the city where the poor are aggregated were much fewer than in many former years. In five of the best wards of the city, in which are the residences of a great proportion of those of wealth, and few of the class of dwellings known as tenement-houses, with a population of 307,046, there were 80 deaths from puerperal fever, while in the remaining wards of the city, with a population of 605,245, there were but sixty-three deaths. In other words, I may say that during this period, in those wards of the city where the causes of septicæmia must have existed in the greatest abundance, the mortality was nearly one third less from puerperal fever, in proportion to the population, than in the best parts of the city, these causes of septicæmia could have existed only in a very limited degree.

I have good cause to remember this epidemic, as the excessive work, mental strain, and loss of sleep which it brought upon me, as my medical friends know, affected my health to a degree that required nearly six years for perfect recovery. I saw ninety five cases during this epidemic, of which nineteen were fatal. Most of the latter I believe to have been fatal in their character from the history which I received, and I only saw them once. I had three cases in my private practice, in one of which the patient died. After this most of the ladies whom I had engaged to attend, by my advice, went out of town for their confinement, and all these had normal convalescence.

From all these considerations, I think that if all the knowledge of this

1. See "Puerperal Disease," by Fordyce Barker, Appendix, p. 515.

disease be derived from authors who have studied it in hospitals exlusively, it will be limited and onesided, and the deductions, both as to its pathology and as to its treatment must in many instances be erroneous and unsafe. Especially must this be the case with those whose well-deserved eminence as operators compels them to be brought in frequent contact with surgical septicæmia and to witness the terrible results which this produces after the most skillful performance of such operations as laparotomy and ovariotomy. Indeed, one can hardly understand how such a surgeon, who accepts the theory and believes in the necessity of such a prophylaxis and such treatment as is insisted upon in the paper under discussion, would ever dare to enter the room of a puerperal woman.

There are many other details in this connection which I am tempted to discuss, but these will doubtless receive due attention from the speakers who will follow me. I will, therefore, content myself by expressing an opinion which will surprise many who have been carried along by the popular wave of the septic theory as the initial cause of most of the puerperal diseases. My conviction is strong, based partly on individual experience, but chiefly on a careful study of the clinical midwifery reports of private practice and all the literature of the subject in my possession—and this is very full as regards the English and French languages—that, outside of hospitals, less than two per cent. of the puerperal diseases and not half of one per cent. of the deaths after childbirth are due to septicæmia. There are no statistics of private practice which demonstrate the error of this opinion. The belief of the septicæmists that terrible dangers threaten every woman in childbirth is based wholly on theory. Because the maternal system has certain peculiarities differing from its normal condition—because the lochia are a poisonous fluid—and because there is always a certain amount of traumatic lesion in the parturient canal following parturition, every child-bearing woman incurs a most hazardous risk. This is a blunt statement of the argument and its deductions.

I do not care to summon in support of the opinion that I have just expressed any higher authority, even if it were possible to do so, than the writer of the paper which we are now discussing and from which I make the following quotations:

"And yet what are the usual results? Recovery, uniformly, I might say universally, unless some unusual occurrence manifests itself to prevent this happy consummation. Theorizing about the matter, one would suppose that the mortality resulting from such a state of things must be excessive." * * * * * * * * * * *

"And yet the facts are these: only about one or two in every one hundred parturient women ordinarily die when properly cared for during labor, even, in public hospitals."

Now, if we recall the fact that a large proportion of deaths from childbirth result from the casualties of labor, such as convulsions, rupture of

uterus, hæmorrhage from placenta prævia, nervous shock, etc., it will be seen that the belief which I have expressed differs but slightly, if any, from his. I certainly find it much more agreeable to refer to our points of agreement than our points of difference.

The limit of time, which, in justice to others who follow, I have allowed myself, will permit but a very few remarks on "the prophylactic measures which should be adopted in all midwifery cases, whether they occur in hospital or in private practice," as the author of the paper distinctly avows. If "she who is about to bring forth" must "be treated as one about to go through the perils of a capital operation"; if all those preparations, so definitely enumerated, which gynæcological surgeons insist upon previous to an ovariotomy or a laparotomy, are necessary in ordinary labors; if the danger from child-bearing be so great that a wise and prudent obstetrician is justified in subjecting his patient to the hazardous depression of intense anxiety and fearful doubt as to results, and in surrounding her with the vivid apprehension of her family, instead of stimulating and cheering her with the great happiness of maternity and the hope of increased interest and love from her husband; if all, or even a considerable part of the details mentioned are necessary "to save thousands of lives which are now lost," and to spare "thousands of desolate households the sorrow of losing their female heads"—then it seems to me evident that the State should make child-bearing a penal offense for all those families who do not have a sufficient annual income to make it possible to carry out all these requirements. Such a law could only be made effective by adopting the facetious suggestion, which appeared in the *Medical Record* of January 19th over the signature of "Seth Hill, Stepney, Conn., making it compulsory for all women unable to carry out these requirements "to wear an antiseptic pad over the vulva from the inception of the catamenia until the menopause, to be non-removable without strict antiseptic precautions under the carbolic spray"; and to secure this pad it would be necessary that some State official should apply the lock, which, no doubt, many present have seen in the Museum de l'Hotel de Cluny, said to have been used by the noblemen of France to prevent their wives from falling during their absence in the Crusades.

The description given of puerperal fever, true as it may be in its outlines, of the septicæmia which gynecological surgeons are so often forced to encounter, I think, will strike obstetricians familiar with the disease in the lying-in chamber as the ideal picture of a poet, differing as much from the scientific description of trained clinical observation as the pictures of natural scenery by a Byron or a George Sand would differ from a scientific description of a mountain or a lake by a Humboldt.

As to diagnosis, I can not regard the symptoms mentioned, even in their totality, as pathognomonic of septicæmia, as all of them are to be found in other puerperal affections, when there is no evidence of septic

absorption, unless with the author it be assumed that all puerperal disturbances are due to this cause alone. It is made an important point by the author to determine whether "the septic disease which is developing has originated in wounds situated between the os internum uteri and the vulva, or in the endometrium, above the former point." He says that "usually the question has to be decided by the efficacy or inefficacy of frequent germicide vaginal injections in bringing down the temperature and controlling other grave symptoms."

Now, I look at this subject from an entirely different point of view, and as I have not the time to examine in detail the treatment inculcated in the paper we are now discussing, I must be content with the expression of my convictions by a few general propositions.

In puerperal fever, as met with in private practice, we have to treat the *consequences* of some form of blood-poisoning. This may or may not be septic poisoning. In private practice, I think it generally due to some occult, possibly atmospheric, epidemic influence; in hospital patients, nosocomial malaria, often associated with septic poisoning.

No treatment which interrupts the normal physiological processes – such as the retrograde metamorphosis of involution, the fatty transformation of the component fibers of the uterus, or the cicatrization of its internal surface by the exudation of organizable lymph, and the development of a new layer of mucous membrane, or the healing of traumatic lesions—can be justified, unless positive symptoms, now well understood in science, demonstrate their necessity.

Antiseptic injections, both vaginal and intra-uterine, are of great service when the indications for their use are clearly shown by local signs or general symptoms; but they can not be recommended with safety as a routine practice on theoretical grounds, as, for obvious reasons, they may be most detrimental in retarding the cicatrization of lesions and the other processes of normal convalescence, and are otherwise sometimes dangerous. In several cases which I have seen with others, where antiseptic injections, both vaginal and intra-uterine, had been used with all the care and precautions inculcated by the author, and kept up for several days, the temperature rapidly fell, the profuse and sometimes offensive vaginal discharges speedily diminished, the pulse and general condition manifestly improved after the injections were discontinued.

I will only add a few words in regard to refrigeration as a means of reducing fever in puerperal diseases. I have no question that it may be useful in some cases, but my own experience in this method of treatment has not been favorable. Many years ago I tried it in several cases in Bellevue Hospital, but I soon gave it up, as the results were less satisfactory than where other plans of treatment were pursued, and I know that this was the conviction of my house staff. Cold will effectively and usefully reduce the temperature in active inflammations and acute fevers,

but in adynamic diseases and in hectic fever this must be attended with a rapid waste of tissue more dangerous than the pyrexia. In three cases which I have seen with others—two a year ago and one this winter—where the coil had been assiduously kept over the abdomen, most of the time two or three days, the conditions in each were remarkably similar. The abdomen was blanched, colorless, and not sensitive to pressure; the patients all avowed that the coil gave them great comfort, but the temperature was very high in all—in one 104.3°, and in the other two over 105°; the pulse was very rapid and feeble, the heart's action extremely weak, with pulmonary symptoms—such as short, rapid, and shallow respiration—which caused grave apprehension that there might be latent centric pneumonia. After some discussion, I induced my friends to remove the refrigerating coil, and, in its place, to cover the abdomen with flannel saturated with the oil of turpentine, for the purpose of stimulating vaso-motor action, restoring the capillary and equalizing the general circulation. All were taking quinine in large doses. This was greatly diminished or wholly stopped, and digitalis and ammonia in full doses were substituted. In a few hours the change in each of these cases was most remarkable; the temperature was reduced from two to three degrees, the pulse was greatly lessened in frequency and increased in force, and all pulmonary symptoms, which had caused so much anxiety, had disappeared. Two of these patients recovered and are still living. The third, who had also been treated by antiseptic vaginal and uterine injection, was apparently convalescent, when suddenly she became much worse; collapse supervened, which was found to be due to a sudden development of diphtheritic membranes which covered the mucous surface of the vulva and vagina, the result of carelessness and dirtiness of the nurse. The patient died in a few hours.

I now ask permission to refer to a matter outside of the question of the prevention and treatment of puerperal fever, but in behalf of the "truth of history." I ask any who may feel sufficient interest to turn to the 320th page of my work on the "Puerperal Diseases," where they will find on this and the following pages the subject of intra-uterine injections fully discussed. Instruments for this use, which had been devised more than fifteen years ago, were shown to the class, and explicit directions were given as to the methods and indications for these injections, differing in no essential from those we heard in this hall on the 6th of December. The lecture was delivered in the amphitheatre of Bellevue Hospital, in February, 1869, and the work in which it was printed was published in January, 1874. Then it may interest some to look at page 85, Volume IV of the "Transactions of the American Gynecological Society," and read the papers of Dr. Edward W. Jenks, of Chicago, and Dr. James R. Chadwick, of Boston, on intra-uterine injections, and the discussion which followed.

In conclusion, I will only add that my creed to-day is fully avowed on page 476 of the book to which I have before referred, and, unless in the future I learn new facts and new arguments to change my faith, I shall "die impenitent."

After the reading of the paper,

Dr. Barker said: The subject is now open for general discussion. So many of the fellows of the Academy have signified their willingness to speak, and there are so many whom all will be anxious to hear, that I felt it to be a duty to limit my remarks in the paper just read to a very restricted time, and to content myself with the enunciation of such general principles as I believe to be important truths, without entering much into details.

But there is one point which I hope will receive attention from the speakers who are to follow. Very early in my practice I began to direct the use of vaginal antiseptic injection for the first week after labor, the antiseptic being Labarraque's solution. When I went on duty at Bellevue Hospital, now nearly thirty years since, this was made the invariable rule in the lying-in wards. Subsequently carbolic acid was substituted, and I gave a formula for its proportions in the work on "Puerperal Diseases." I have habitually directed its use in all my obstetric cases until the past two or three years.

At the time of the International Congress in London, in 1881, I happened to be seated at a dinner next Dr. Thomas Keith, of Edinburgh, and had a very interesting conversation with him as to the use of antiseptics in ovariotomy. What he said was very suggestive, and led to a good deal of subsequent reflection on my part as to the use of antiseptics in obstetrics. I recalled to mind the fact that often in my practice I had seen disturbances and interruptions of puerperal convalescence the first week after labor, and it occurred to me whether this might not be due to the carbolic acid; and the following autumn I decreased the proportion of the carbolic acid one half, and thought that my patients did better. On further reflection on the subject, I said to myself the carbolic acid, even in the larger proportions which I have formerly used, was not strong enough to destroy the micro-organisms. Is it not possible that Nature has wisely arranged to furnish the best fluid for constantly bathing the bruised and lacerated tissues of the parturient canal in the much-maligned lochia? Are not absolute rest and freedom from disturbance of these tissues much more favorable to their restoration than any washes that can be used? Since that time I have considerably surprised nurses by directing that no injections should ever be used unless specially ordered. It is scarcely necessary to say that absolute cleanliness was strongly enjoined, and that not a spot of blood, either on the bedding or on the clothing of the patient, should be found.

Dr. A. A. Smith, who frequently visits my patients when I have other

engagements, during the first puerperal week, tells me that this direction was given more than two years ago. Since September, 1882, it is only in a small proportion of my obstetrical cases that I have seen any reason for ordering even vaginal injections, and Dr. Smith informs me that this is true of his own cases. We both can declare that since that, including even instrumental deliveries, we have not had a single case in our practice which during the puerperal period has given us any anxiety or required more than an ordinary attendance of one daily visit for nine days.

This may be only a happy coincidence, but it seems to me significant, and I think most present may like to hear the views of others on this new departure. [To be concluded in our next issue].

Editor's Table.

MALIGNANT DISEASE OF THE CERVIX UTERI. — The following very interesting case is taken from a Gynecological Clinic by Prof. T. G. Thomas, of New York:

Gentlemen:—Our first patient to-day is Mrs. Eliza C—, a native of the United States. She has been married thirty-five years, and I will ask her to tell us in her own words what she is suffering from. She says she has back ache and the whites; upon questioning her I get the statement that the discharge is water, and to the amount of about a pint and a half in twenty-four hours. These are the only symptoms which she considers important enough to present to us. She has been under the care of several physicians, only one of whom has examined her by the vagina. I do not get these points for the purpose of criticising the physicians, but that I may impress upon you the great value of always suggesting a vaginal examination of every patient presenting herself with symptoms that lead you to suspect the uterus. Have we anything in the symptoms which this patient presents us tending to criminate the uterus? Doubtless many of you are thinking of the profuse watery discharge, and let me earnestly urge you never to prescribe for a woman who speaks of having a watery discharge until you have examined her, for this is one of the rarest forms of discharges which you will meet with. Bloody or mucous discharges are comparatively common, but when you meet with a vaginal discharge which is profuse and watery, always remember that this is a symptom of malignant disease. I call to mind the case of a lady who was referred to me by several physicians from a distance, gentlemen whom I knew to be intelligent and competent. This lady had been under treatment for a year and a half, but as the only symptom of which she complained was hydrorrhœa, none of these gentlemen had made a

vaginal examination. Upon examining her I found the cervix entirely gone, and only the fundus and outer wall of the uterus left to show the results of epithelioma. Now imagine how one of you would feel if you had been treating a lady for a year and a half, without having examined her, and then some rival practitioner should be called in to make an examination; but to return to our patient of to-day. When I examined her in the ante-room, I found the vagina midway between the cervix uteri and the ostium vagina constricted by a firm, velvety feeling ring of tissue, which is brittle under my finger, easily breaking down. This is malignant tissue, and is the cause of the serous discharge, by obstructing the blood vessels.

Now we are in the light as far as diagnosis is concerned, but as regards prognosis and treatment we can not say as much. I have already allowed the patient to pass from the room in order that she may not hear her case discussed. The prognosis in this case is bad. The treatment in her case will be only pallative. The pain in her back will become more severe, and will require opium for its relief. But we can not cure her, I would not consider an operation advisable. She suspects the nature of her disease, and to reassure her I have told her that she has a disease resembling cancer, and called epithelioma.

VAGINAL HYSTERECTOMY FOR EPITHELIOMA OF THE CERVIX UTERI.—Dr. Paul F. Munde related to the Obstetrical Society of New York, October 16, 2883, a case of epithelioma of the cervix uteri in which he had removed the uterus and the ovaries by the vaginal method, at Mount Sinai Hospital six days before. The specimen was shown, and, as Dr. Munde remarked, it seemed to indicate that the diseased tissue had been thoroughly removed. Thus far the patient had done perfectly well. It was now a question of how long the drainage tube should be left in place. It was held by a flange, and there was no leakage around it.

Dr. I. A. Emmet thought the tube would have become so encysted at the end of a week as to answer no further purpose.

[NOTE.—Dr. Munde makes the following note on this case in the *American Journal of Obstetrics* for February. The tube was removed on the eighth day, the ligatures and sutures on the sixteenth, all but one ligature, which was still retained five weeks after the operation. The patient left her bed on the fourteenth day and the house during the fourth week, and (January 20, 1884) thus far remains well.

WE take pleasure in calling the attention of our readers to the Cincinnati Sanitarium, advertised in this issue of the OBSTETRIC GAZETTE. Its advantages for the treatment of mental and nervous diseases are unsurpassed. The perfect salubrity of the location, combining also the advantages of country seclusion with easy access to and from the city, are

among its many inducements. The responsibility of the institution is assured. It is no longer an experiment, but that of permanency, based upon success. The rates of charges are governed by circumstances, the character of the disease, the amount of attention required, rooms occupied, etc. For full and complete information address the superintendent.

THE WET PACK IN SCARLET FEVER. — Dr. A. F. Rundell, in *Medical Call*, speaks highly of this remedy. He says he always puts the patient in a wet pack, if called before the rash is thoroughly out, and before desquamation begins to take place, using water at the temperature of 67 to 70 degrees. The patient is left in the pack from one-half to three-quarters of an hour, and is given all the cold water he wants to drink. The pack may be repeated to reduce fever. He finds this treatment to act nicely in allaying fever and bringing out the rash.

SIMS MEMORIAL FUND. — The friends of the late Dr. J. M. Sims propose to erect a suitable monument to his memory. In recognition of his remarkable contributions to Gynecological Surgery, nothing could be more fitting or graceful. To this end a committee, of which Dr. Fordyce Barker is President and Dr. Geo. F. Shrady is Secretary, has been appointed, with representative gentlemen in every part of the country. Contributions of one dollar and upward are solicited, and all such contributions may be sent to the care of the OBSTETRIC GAZETTE. The eminent services of Dr. Sims, his genial character, his unselfish devotion to his work all indicate the propriety of this enterprise, and would seem to insure its success.

ENTERTAINMENT OF PROF. PARVIN. — The Alumni Association of Jefferson Medical College, of Philadelphia, gave a grand Reception to their new acquisition in Professor Parvin to the obstetrical chair. The reception was given on the evening of January 28th. Without doubt, the meeting of Philadelphia's distinguished physicians on an occasion of this sort was a high compliment to the new Professor. There would be the veteran Gross, always good and worthy; many others, whom to name would be invidious. We have no memoranda of the proceedings, but we can easily imagine the bill of fare. Thanks to the committee for the invitation to be present.

OBSTINATE ULCER OF THE TONGUE IN A CHILD. — Dr. Kemper, of Muncie, Ind., reports to the *American Journal of Obstetrics* a case where he became satisfied the ulcer was a result of the tongue gliding over the lower central incisors—the only teeth in the lower jaw—during the act of nursing, and so a constant irritation was kept up. He suggested weaning the babe, age twelve months, and the ulcer healed without other treatment in about two weeks.